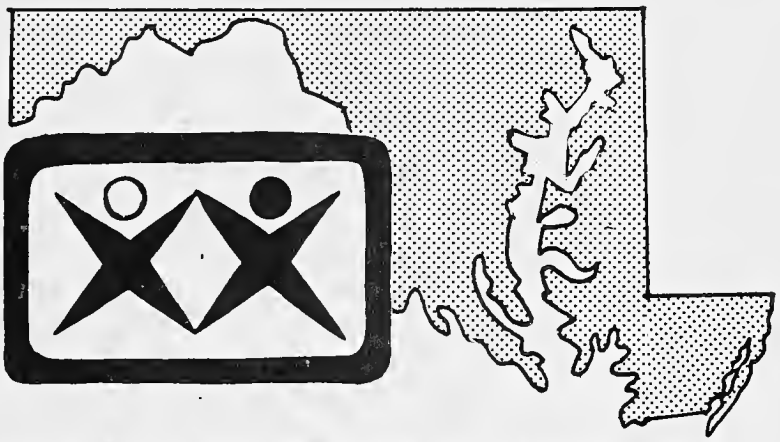
DEINSTITUTIONALIZATION:

PROBLEMS AND OPPORTUNITIES



MARYLAND DEPARTMENT OF STATE PLANNING

Deinstitutionalization: Problems and Opportunities

MARYLAND DEPARTMENT OF STATE PLANNING

MARCH 1976

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Governor of the State of Maryland

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May 18, 1976

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ar Governor Mandel:

I am pleased to hereby transmit to you a copy of the report "Deinstitu-onalization: Problems and Opportunities." This report was prepared by the partment of State Planning in response to a request made by the 1975 ssion of the Legislature in HJR 55 and supported by the interest expressed the topic by a variety of State agencies. Consequently, this report will so be presented to the appropriate Committees of the General Assembly and appropriate State officials.

Extensive research into the deinstitutionalization plans of the State encies and the problems encountered in implementation of these plans was nducted. Broad participation by State agency officials was utilized in is aspect of the work as well as in review of the draft report. The ews of private group home sponsors and community groups were also licited and recorded in the report. The intent of this undertaking was examine the concept of deinstitutionalization, identify problem areas d suggest potential means of resolving the difficulties.

It is our hope that this report will prove useful to you and the riety of other State officials faced with the need to make difficult cisions regarding community treatment programs and approaches. It may so aid in the implementation of the new Community Corrections Act. we can provide additional assistance, please let me know.

Sincerely,

Vladimir Wahbe

Vladimir Wahbe

achment

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LIST OF ACRONYMS

ARC - Association for Retarded Citizens

BPW - Board of Public Works

CETA - Comprehensive Employment and Training Act of 1974

CINS - Children In Need of Supervision

COMP - Comprehensive Offender Model Program

CCTF - Community Corrections Task Force

DAA - Drug Abuse Administration (within DHMH)

DAC - Division of Alcohol Control (within DHMH)

DBFP - Department of Budget and Fiscal Planning

DDC - Developmental Disabilities Council (within DHMH)

DGS - Department of General Services

DHMH - Department of Health and Mental Hygiene

DHR - Department of Human Resources

DPSCS - Department of Public Safety and Correctional Services

DSP - Department of State Planning

EP - Educational Programs

EPP - Executive Planning Process or Executive Plans

ES - Employment Security

GES - Geriatric Evaluation Service

GAO - General Accounting Office

HSC - Human Services Council

JSA - Juvenile Services Administration

LEA - Local Education Agencies

LEAA - Law Enforcement Assistance Administration

MAP - Mutual Agreement Programming

MARFY - Maryland Association of Residential Facilities for Youth

MEP - Maryland Model Ex-Offender Program

MHA - Mental Hygiene Administration (within DHMH)

MRA - Mental Retardation Administration (within DHMH)

MSDE - Maryland State Department of Education

OA - Office on Aging

RFP - "Request for Proposal"

SSA - Social Services Administration (within DHR)

SSI - Supplemental Security Income

VA - Veterans' Administration

YSB - Youth Services Bureau

Summary of Findings and Recommendations

The findings outlined below represent the major observations to be drawn from the research on deinstitutionalization in Maryland. The findings resulted from a review of the plans of a variety of State agencies and a series of interviews with individuals involved in various phases of the deinstitutionalization process.

A. OVERVIEW OF FINDINGS

1. Statewide deinstitutionalization efforts lack a centralized policy or decision-making body:

It is clear that a state-wide effort to deinstitutionalize exists among human services agencies. However, the policy for these efforts appears to have emerged from a variety of sources including the Federal government, the Governor, the State legislature, State agencies, the courts, human service professionals, and citizens and interest groups. As a result of the variety of policy-makers and their differing motivations, agency policies and programs have developed independently and without regard to the deliberate effects on the total system. Because no formal mechanism exists at the State level to interpret or coordinate deinstitutionalization policies, there is no arena in which conflicts can be addressed and coherent approaches discussed. In addition, the absence of a coordinative approach has resulted in an excessive number of community treatment programs being placed in selected communities.

2. Despite deinstitutionalization, the expenditures for institutional care may remain high:

Since it is not possible to remove all patients from institutional settings, the need for such facilities will continue. To obtain federal Medicaid/Medicare payments for institutional care, staffing levels and life-safety provisions may need to be upgraded. Thus total expenses for institutional care may not decline significantly with reductions in patient load.

3. Lack of needs and resource assessments and projections:

Few agencies have been able to project specific facility and program needs, or developed plans to meet those needs through 1981. As would be expected, experienced agencies are more sophisticated and better able to assess needs and to make projections than many others. Inadequate or unrealistic projections make it difficult to equitably allocate resources. They cannot

be responsive to the financial realities and there may be a lack of thorough planning within the agency as to direction, needs and accomplishments.

4. Lack of prioritizing or phasing of deinstitutionalization plans:

Few agency plans include any prioritizing or phasing with regard to services, facilities plans, and geographic areas to be served. The lack of priorities and phasing could signify the failure of the agency to come to grips with and develop a Statewide plan for its deinstitutionalization efforts. With already scarce resources, and without any prioritizing or phasing, this "scatter shot" approach spreads the agency too thin and its achievements may be limited.

5. Lack of funds impedes implementation of deinstitutionalization:

Without centralized decision-making on funding priorities, and given the weaknesses of many plans, a variety of programs serving different target populations have been funded at inadequate levels. Resources have not been channeled or concentrated to implement the program or service of greatest importance to the public. Plans for deinstitutionalization have been developed but could not be totally implemented due to shortages of funds. Few of the agencies directly addressed this problem in their plans; instead, they expend energy on program planning as if the financial problems did not exist. This has created credibility problems with communities that distrust statements about the service and level of staff that will be available in community residences.

6. Need for stronger Executive/Legislative leadership:

Despite statements endorsing the deinstitutionalization concept, stronger and more consistent support is needed to successfully implement deinstitutionalization. Community opposition to sites has at times received support from local officials and has successfully stymied various proposals. Approved funding levels have not always been sufficient to initiate or sustain planned community residential programs

7. Emphasis on children and adolescents in the deinstitutionalization process:

Throughout the State, policies appear to emphasize the release or diversion of children and adolescents from institutions seemingly because of the belief that the environment and treatment in large institutions does not permit appropriate care of the youngsters.

8. Community residences are an integral component of each agency's deinstitutionalization program:

In reviewing the agency plans, some kind of community living arrangement is an integral part of their deinstitutionalization

system. Various terms have been used to describe these facilities and each term reflects the tremendous variation in philosophy, capacity, program, and length and kind of treatment. Community residences have been used as the generic term to describe these living arrangements. These residences connote 24 hour care, a residential capacity, a concentration of at least 4 clients, and minimal or no security provisions. The differences between these community residences create difficulties in making inter- and intra-agency comparisons and evaluations and in developing comprehensive governing policies.

9. Emphasis on family care as an alternative to institutionalization:

State agency plans emphasize treatment of a child or adult in need by his or her natural family. Because most families are not equipped financially or emotionally to rehabilitate a disabled or troubled individual, each agency's plan recommends the inclusion of support services which would provide the family with the extra amount of strength and stability all members might need to care for the individual.

10. Emphasis on community services:

In order to support a person who has been released or diverted from an institution, most agencies emphasize the need for community services as an integral part of their deinstitutionalization system. These services may include homemaker services and home health care, day care, counseling, screening, diagnosis and evaluation, socialization and other rehabilitation programs. They are often provided by the local health and social service agencies or private sponsors. With the help of these services, persons can live independently or with a lesser level of care such as that provided in a foster home.

11. State agency plans - private sector implementation:

In reviewing agency plans, it appears that each has considerable control over deinstitutionalization planning but minimal control over implementation. One of the major reasons for this discrepancy is the State policy which discourages agencies from getting into the direct delivery of services; they rely upon the initiative of private agencies to provide services. For these services, State agencies reimburse private agencies for their costs through predetermined purchase of care rates.

12. The constraint of community resistance:

There is considerable agreement that public opposition is one of the major impediments to deinstitutionalization. Public opposition is focused on the establishment of community residences. While resistance is the norm, community living for some groups such as the elderly appears to engender less hostility than others. Despite the importance of community resistance, with few exceptions, agency plans did not identify this as a

problem. Therefore, they did not propose any strategies for dealing with it. Most agencies rely upon special advocacy groups and the private sponsors to neutralize community resistance.

13. Lack of evaluative research:

Little evaluative research has been conducted by State agencies on deinstitutionalization programs although many have plans for such efforts within the next five years. Therefore, little data is available to help convince legislators, community representatives, and others about the merits of the approach. In particular, little financial analysis has been conducted regarding the cost-benefits of deinstitutionalization. It is popularly believed that deinstitutional programs are less expensive; this assumption needs to be studied.

B. OVERVIEW OF RECOMMENDATIONS

The last chapter of this report contains detailed recommendations for solving or ameliorating the problems identified in the study. The list below briefly reviews the recommendations.

1. Establishment of a three-part structure to coordinate deinstitutionalization:

A three-part structure is needed to coordinate deinstitutionalization initiatives within State agencies, between State agencies, with private sponsors and between State and local governments. This recommendation involves creation of two State level task forces: one for policy formulation and a second at the program managers level to coordinate operations. A local counterpart task force in each county would be established to work with the State.

2. Preparation of joint Executive-Legislative policy statement:

A joint Executive-Legislative policy statement with regard to community-based treatment programs should be developed to set the framework for deinstitutionalization activities. For this statement, a reassessment of State policies and performances regarding institutional care would be appropriate. The feasibility of deinstitutionalization given available funds, services and appropriate placements should be considered. Locational criteria should be developed as well.

3. Reassessment of funding levels and procedures:

If deinstitutionalization is to be accomplished at the same time that efforts are made to assure quality of care in State institutions, there must be recognition of the need for sufficient funding levels to State service agencies. Funding sources and funding mechanisms need to be examined and analyzed. It may be

possible to free some funds through elimination of programs that can no longer be justified. Evaluation of on-going programs for this purpose is needed.

4. Evaluation of purchase of care rates:

Purchase of care rates should be evaluated to determine the adequacy of the rate and the need for differentials based on location and the individual case. The desirability of this method of funding should be reviewed.

5. Testing and new strategies for responding to community concerns:

New strategies need to be considered for responding to the concerns of the host communities. State operated residences for certain target populations, incremental development of residential facilities, smaller group homes, assigning local governments responsibility for implementing community alternatives, local advocates and creation of a compromise agent are suggestions worthy of consideration.

6. Expansion of community education efforts:

Increased community education about the deinstitutional approach and the needs and problems of the client groups should be achieved through a unified and generalized State publicity campaign. Site specific educational efforts would be a joint responsibility of the State agency and local sponsors.

7. Evaluation of existing deinstitutionalization programs:

Evaluation of existing community residences is needed to determine their success and provide answers to many long-standing questions about the approach. Evaluation would be conducted jointly by the Department of Budget and Fiscal Planning, the Department of Fiscal Services and the program managers.

8. Testing of alternative forms of diversion:

Experimentation with other forms of diversion such as location of a group home on the grounds of a State hospital or university, creation of "families" of clients in treatment, support services for individuals residing in the community and companion living should be encouraged.

9. Strengthening of transitional planning:

Improved transitional planning involving institutional and community service staffs is essential to successful reorientation of clients.

10. Establishment of staff training programs:

Interagency training for those staffing community residences should be initiated.

11. Encouragement of joint ventures:

Joint ventures in developing and operating community residences should be considered including sharing of facilities and specialized services and joint purchasing of supplies.

12. Preparation of model zoning and regulatory ordinances:

Model zoning and regulatory ordinances to adequately safeguard residents of group homes and the interests of communities should be prepared.

I.

Deinstitutionalization: The Concept

As modern and enlightened government has evolved, one of its major functions has been to provide care and treatment for those citizens who have limited or no financial resources. The helpless and dependent, poor, sick, aged and anti-social have become the responsibility of the public and the State. Over time, there have been changes in the way the State exercises its responsibilities. One of the early reforms was to construct institutions wherein these different groups would be cared for and treated. It was felt that treatment within the confines of an institution would provide the array of services needed for rehabilitation. In addition, segregation of the misfits created a more pleasant and homogeneous life for the larger society.

For the past decade, the pendulum has swung away from institutionalization toward deinstitutionalization. In its broadest sense, deinstitutionalization results from the change in philosophy about care and treatment which discourages reliance and dependence upon long term, traditional institutional care and encourages the development of alternatives to institutionalization for all those in need. The effects of this overall approach have been felt in the development of policies and programs in the functional human service areas which include education, health, social services and criminal justice.

The roots of the deinstitutional emphasis spring from a dissatisfaction with large care and treatment institutions. This dissatisfaction has several elements. First, concern has been expressed over the over-

crowding, staff shortages and other unfavorable physical conditions within facilities which make it difficult to provide a decent and dignified institutional life. Secondarily, and because of these conditions, questions have arisen about the effectiveness of treatment programs. The high recidivism of offenders and the revolving door patterns of mental patients have focused increasing attention on the success-failure rates of institutional rehabilitation. In addition to these difficulties, rising costs have required institutions to ask for larger budgets at the same time public bodies are beginning to question the effectiveness of the system.

This lack of confidence in institutions has led many policy-makers and program personnel to seek alternative care and treatment arrangements. The State has developed programs which require the community to assume some of the responsibilities for the rehabilitation process. Coupled with this decentralization of responsibility, is the belief that there are unique resources within community living that can aid in the rehabilitation process. Contact between the community and individuals in treatment is expected to aid in integrating the population served into society.

As a concept or modality of care or treatment, many different programmable approaches have been developed to implement deinstitutionalization. Despite these differences, there is agreement that deinstitutionalization is a continuum which affects and has implications for institutions, the client and the community. The continuum includes four major components: institutional reform, depopulation of institutions, alternative living arrangements and preventive measures.

The need for institutional reform is based on the belief that despite the movement toward community based care, institutional care is still appropriate for many people. Therefore, the environment in the institutions must be acceptable for those who need to be admitted. To this end, officials of institutions, clients, advocacy groups and others are concerned about humane conditions, and inadequate or ill-trained staff, and inappropriate admissions. In many cases, these conditions have resulted from "dumping" of clients into the large institutions because of the absence of more appropriate treatment facilities. Both the legislature and the courts have joined others in expressing concern over the need for institutional reform, and in developing broad policies which make such reform mandatory. The Federal government has also become party to the trend by creating more comprehensive and restrictive regulations that must be met in order to secure reimbusements for institutional care.

Depopulation of institutions is another major step in the deinstitutionalization process. In order to implement this policy, large numbers of patients judged to be capable of community life, not "sick" enough for confinement or no longer benefiting from treatment in institutions, have been released from institutions. Those patients who are released to their own care are sometimes released at the expense of their own well-being. Many of them are not capable of maintaining or not adequately prepared for, community life. Without the necessary skills, they are subject to deterioration, malnutrition, poor housing, lack of social contact, and can become the unwitting victims of exploiters. Lack of proper screening for eligible releases, minimal transition planning and linkage with community support services, inadequate placement opportunities and lack

of follow-up have created serious policy and programmatic issues for this aspect of deinstitutionalization.

To complete the deinstitutionalization continuum, alternatives to institutionalization must be developed. In order to keep people out of institutions or to serve them when they are released, new living arrangements and systems of care must be available. One approach has been to prevent institutionalization from the outset. Through the provision of community based support services, the problem that could lead to institutionalization is dealt with and personal care and independent living among those at risk of institutionalization is promoted.

Another approach has been to provide supervised care through the creation of "bridge" institutions. These institutions are normally smaller, community-based and provide residential services for those persons being diverted or released from institutions. They include foster care homes, group homes, day care programs, treatment centers, half-way houses, sheltered or congregate housing and domiciliary care institutions.

Another alternative to institutionalization is family care. Historically, and in some rural areas today, the family was the institution that provided shelter and care to its disabled. However, the American family has gone through dramatic changes in the past decades which make it difficult for it to continue to play this role. Mobility has not only threatened the extinction of the extended family but has also undermined the development of other supports that come from stability such as deep and long-standing friendships. Economic circumstances often require that both partners in the marriage work, and many familes feel ill-equipped to deal with a family member with a disability. As a

result of these and other factors, the family will not or cannot provide care for the individual, and institutionalization remains the only alternative. Currently, attempts are being made to provide support services to families to help them reassume their nurturing responsibilities.

II.

Department of State Planning Study Efforts

As in other states, many agencies in Maryland are engaged in or about to engage in one or more aspects of the deinstitutionalization process. Because of a lack of funds, expertise, guidelines and other resources, many of the programs have proven difficult to implement. In addition to the lack of resources, many communities and other special interest groups have resisted the movement for a variety of reasons including fear for their own safety, concern about the effects of the movement on property values and neighborhood conditions, or because of the belief that without adequate supportive resources, deinstitutionalization would be harmful to the client.

Largely, because of these difficulties, the Human Services Task Force, which advises the Department of State Planning on the Human Services Planning and Coordination Project, identified deinstitutionalization and the problems associated with implementation of the policy as ones causing difficulties for many of the agencies. Subsequently, the Task Force requested the staff of the Department of State Planning to study these common problems and to recommend methods by which some of these difficulties might be resolved.

Prior to any work, however, DSP reviewed the scope and progress of a study being conducted by the Federal General Accounting Office (GAO) on the progress and problems of deinstitutionalization in five states, with emphasis on the activities in Maryland and Oregon. It was and is the intent of DSP to avoid the extent possible any duplication with

this report. Thereafter, a methodology was developed for the deinstitutionalization study.

The first step in the DSP methodology was to conduct a comprehensive review of the FY '77 Executive Plans of the following agencies:

° Department of Health and Mental Hygiene

-- Mental Retardation Administration
-- Mental Hygiene Administration
-- Division of Alcohol Control
-- Office of the Secretary: Health Education Center
-- Drug Abuse Administration
-- Preventive Medicine Administration
-- Medical Care Programs
-- Juvenile Services Administration
-- Services to the Chronically Ill and Aging
-- Developmental Disabilities Council

° Office on Aging/Commission on Aging

° Department of Human Resources

-- Employment Services Administration
-- Social Services Administration

° Department of Education

-- Division of Special Education
-- Division of Library Services

° Department of Public Safety and Correctional Services

-- Community Corrections Task Force

The purpose of the review was to identify the commitment and intent of each agency toward deinstitutionalization, the priority of the intent, implementation plans, and the relationship of programs to the plans. It was also intended to develop an understanding of the interagency relationships that exist in deinstitutionalization efforts. The review also took particular note of the problems being experienced by agencies in this process and potential opportunities for dealing with these difficulties.

It is important to note that the EPP plans provided an excellent vehicle for the comprehensive review of departmental activities. Without them, considerable time would have been spent identifying, collecting and organizing data. Because of the structure of the reports, a review could be made of each agency's attempt to identify plans for deinstitutionalization, to identify and assess needs and resources, to develop goals with proposed strategies and programs and to discuss the implication of plans on State fiscal, regulatory and managerial policies. This information provided an important basis and point of departure for more thorough analysis.

After this review, a meeting was called of agencies involved in deinstitutionalization efforts. Representatives from the DHMH, MSDE, Office on Aging, Department of Public Safety and Correctional Services, Developmental Disabilities Council and DHR attended the meeting. The purpose was twofold: first, to promote dialogue among agency personnel about common problems, interagency conflicts and possible solutions; and second, to get some consensus on the priority of issues so that DSP could focus its research and analysis on the problems of greatest concern.

As a result of this meeting, it was determined that priority should be given to three issues, all of which inhibit deinstitutionalization efforts:

1. Community resistance
2. Lack of supportive services in community
3. Administrative, procedural and policy conflicts

A preliminary outline distributed at the meeting was revised to incorporate the issues raised at the meeting and was sent to all participants for comment. Those comments received were subsequently included.

Thereafter, indepth interviews were conducted with many of the agency representatives who attended the meeting held by DSP. The interviews were designed to enable the DSP staff to become more familiar with the deinstitutionalization efforts of the agencies and to augment and verify the information and conclusions reached during the plan review phase. In addition, they provided an opportunity to determine in greater detail, the agencies' experiences with community resistance, lack of community services and administrative conflicts. Interviewees were also asked for suggestions as to how deinstitutionalization could be implemented more easily.

Another purpose of the interview was to begin compiling an inventory of community-based residences sponsored directly by the agencies or by private agencies which are financed by purchase of care arrangements with the State. This procedure, by which the private sector becomes responsible for the care and treatment of many persons at risk of institutionalization, will be discussed in greater detail in subsequent sections of this report. Locations of these facilities were pinpointed on a State map to demonstrate the spread and concentration of the community-based facilities throughout the State. This map appears in Section III, p.40 .

In addition to conferring with State officials, DSP staff also met with representatives of several community groups. Interviews were also scheduled with sponsors of community-based facilities to discuss their experience with individual state programs and community response. The purpose of these meetings was to discuss and assess community response to deinstitutionalization and community-based facilities. It was also felt by DSP staff that this contact with local representatives would

provide the basis for a more balanced report which accurately reflected the attitudes and concerns of all sectors involved in the deinstitutionalization process.

After reviewing and documenting the deinstitutionalization activities in the State of Maryland, the DSP staff proceeded to conduct a literature search to identify successful approaches or models developed to deal with the problems that were highlighted at the interdepartmental meeting. In addition, contact was made with program officials in other states to learn of their experiences with deinstitutionalization and methods they may have developed to facilitate the implementation process.

III.

Deinstitutionalization in the State of Maryland

A. STATE AGENCIES

Based on the Executive Plan reviews and the interview process, certain general findings emerged about the State-wide deinstitutionalization activities at the State level, along with specific observations about individual departmental plans and policies. These are discussed below; more detailed reports of agency plans are available on request.

Department of Health and Mental Hygiene (DHMH)

The bulk of deinstitutionalization within Maryland occurs as a result of DHMH activities. DHMH has been given the responsibility for providing health care to a wide variety of target groups, the mentally ill and mentally retarded, physically ill and disabled, the aged, the indigent, pre-delinquent and delinquent children, and alcohol and drug abusers. In the past, most of these groups were treated in institutions. There is now a department-wide policy to deinstitutionalize which affects nearly every service delivery unit within the agency. Each of the administrations, divisions and programs within DHMH has been called upon to meet the departmental goal of increasing the number of people who can attain a level of self-sufficiency by receiving services in a home or community environment.

Underlying the Department's commitment to deinstitutionalization is the need to reduce the inpatient caseload at State

hospitals. Costs of staff, maintenance and the need for expansion and/or renovation have apparently created great pressures to cut back on admissions. A policy of deinstitutionalization which includes prevention, diversion and community treatment and living alternatives provides initial relief from these operating difficulties. While such action may solve the immediate crisis, additional long term considerations should be taken into account. Adequate consideration has not been given to the implications of such a policy which include the nature of the hospital's continuing responsibility for the ex-patient, the budget necessary to provide the supportive facilities and services which will be needed to maintain the patient in a community setting and the impact on and the resource of the patient if these services are not available.

DHMH experiences the same problems and limitations as other agencies in designing and implementing deinstitutionalization policies, plans and programs. However, since the vast majority of deinstitutionalized persons are wards of DHMH, these problems and limitations could have greater impact on this Department. In addition, the diverse needs of its many different client groups make the task of providing comprehensive deinstitutionalization programs all the more difficult.

There appear to be certain features of DHMH deinstitutionalization plans that are unique to the Department. First, DHMH has local branches within each county, the local health department and the local juvenile services office. These local units are to be the planning and operating arms of the Department for implementing deinstitutionalization, as well as other policies.

This network could be an important asset to the decentralization/ deinstitutionalization effort. However, as with other deinstitutionalization concepts, sufficient resources have not been allocated to insure implementation. Little additional funding and technical assistance will be available, particularly to the local health departments, to meet these expanded responsibilities. Without adequate financial and technical support, these organizations will not be able to take advantage of their grass roots character to "sell" the policy to local communities and implement deinstitutionalization.

Because of many of the DHMH charges are children, there is a strong emphasis on the benefits of remaining in the family unit. The family emphasis is also applied to some adults, such as the mentally ill and alcoholics. Personnel in the Department agree that the success of such family care is dependent upon the availability of supportive services. Unfortunately, the Department reports that sufficient funds necessary to provide the support services will not be forthcoming.

Another characteristic of the DHMH deinstitutionalization program is the development of quasi-institutional living arrangements on the grounds of the State hospitals. These living facilities offer less intensive care than inpatient care but give the individual the supervision needed. In addition, the on-site facilities make use of State-owned land and existing staff. These facilities, although few in number, seem to be a promising alternative for those patients who are sufficiently independent for community life. These sites may also offer an alternative to communication locations which often arouse serious if not obstructive neighborhood resistance.

Each of the units within DHMH addresses the specific needs of its client group when interpreting the Departmental deinstitutionalization goal. Chronically Ill and Aging clients are usually receiving inpatient care in some health institution. Therefore, the unit's commitment to deinstitutionalization is defined as the avoidance of inappropriate institutionalization. The Hospital Treatment Service will provide various categories of ambulatory and community based care including day hospital and treatment units on the grounds of Deer's Head, Montebello and Western Maryland State Hospitals.

Services to the Aging, like other sections within Chronically Ill and Aging is also committed to avoiding inappropriate admissions to institutions. However, its target subgroup is the elderly population. Institutionalization of the elderly is a common occurrence and is often done prematurely because of the lack of alternative living arrangements. Once institutionalized, the patient rarely improves; his or her condition is generally maintained at the admission status or worsens. In addition to its emphasis on diversion, the division is also responsible for the elderly population in institutions, many of whom have grown old within the facility and are not able to function independently in the outside world.

For the elderly in and out of institutions, the agency expects to provide the highest level of independent living each patient can manage. It is hoped that diversion can be achieved through the Geriatric Evaluation Service which provides screening and high quality evaluation and treatment prior to institutionalization in a

State mental hospital. The goal is to set up GES programs in those twelve jurisdictions which have the highest admission rate of elderly into long term care facilities. Through these GES efforts, it is hoped that more elderly persons can be stabilized and maintained in the community.

For those institutionalized elderly who will not benefit from continued psychiatric service, the division has provided nursing units on the grounds of Spring Grove and Mt. Wilson Hospitals, which house between 120-140 patients. A third unit is scheduled to open in the near future.

For the elderly being diverted or released from institutions, day care programs are being established. These programs are not custodial, but provide treatment and rehabilitative services. In addition, they provide a needed respite for natural or foster families that are caring for the elderly patient.

In the Mental Hygiene Administration (MHA), deinstitutionalization becomes absorbed under the continuation of care and unitization concepts. The county forms the basis for the unitization system and within each county, the full range of mental health services is to be available to each person through close cooperation between hospitals and community programs. The community programs envisioned are community mental health centers, specialized foster care, halfway houses, special services to families and day care services. Much of the focus of the concept is on the community mental health center which is to provide outreach, counseling and follow-up for those people who come to the center and those released from the State hospitals.

While the system works well in theory, in reality the resources of community programs are too scarce to meet the demands of the model. Community mental health centers are absorbed in providing direct services and have few resources left for outreach and follow-up, particularly for ex-hospital patients and families that are caring for their own relatives. Foster care is not abundant because of the low purchase of care reimbursement. Only two halfway houses exist for the more independent and day care is minimal.

The MHA has stated that support for its community programs may not be forthcoming. Staff has estimated that the 6,400 annual admissions to State hospitals would drop to 3,650 if adequate community based services were available. Without these services, it is estimated that the admission rate will drop to 4,200.

It is important to note that much of this estimated decrease in admissions from 6,400 to 4,200 will not be reflective of a decrease in the number of mental patients admitted because of the work of the community mental health centers. Rather, the decrease in admissions will result largely from the diversion of alcoholics from the mental hospitals to community treatment programs. In this effort, the Division of Alcohol Control within the DHMH, is committed to eliminating all alcohol related admissions to State mental hospitals by 1981.

Traditionally, alcoholics have been treated in jails or in general hospitals. Long-term cases were handled in the Alcohol Rehabilitation Units of the State mental hospitals. With the passage of Article 2 (c) in 1968, which decriminalized public intoxication, the criminal justice system was relieved of the responsibility

of caring for and adjudicating public inebriates. Unfortunately, no alternative programs were available to carry this burden. This legal change corresponded with the policies of the DHMH to reduce admissions at State hospitals and with the acknowledgement that inpatient care, while helpful in the detoxification state, was too labor intensive and provided no long-term rehabilitation services.

The thrust of the Division of Alcohol Control (DAC) deinstitutionalization efforts has been to emphasize the non-criminal nature of alcoholism. The staff feels that an alcoholic, like any other victim of a non-communicable disease, is entitled to live in the community. In order to implement this concept, a system of community living arrangements in quarterway or halfway houses has been developed.

In addition to living arrangements, DAC also provides alcohol counseling through the local health departments. It is also trying to prevent alcoholics from entering the system by encouraging them to remain with their home communities and families wherever possible. For example, a day care program for alcoholics on the Eastern Shore is providing respite for families and helping to prevent the alcoholics from wandering away into the urban centers for help.

In fulfilling its responsibilities to care for children and adolescents, MHA appears to be headed in the direction of removing children and adolescents from State hospitals. Staff feel that such institutionalization is inappropriate for children and in the case of adolescents, housed with adult patients, the outcome is often harmful to the adolescent. Recent court decisions requiring the separation of Montgomery County adolescents from adult patients in the hospitals have been informally interpreted to require such

separation for all Maryland children. The court order requires immediate implementation. There are inadequate facilities in the community to separate juveniles from adults. Therefore, this may impede deinstitutionalization because a greater proportion of resources may have to be spent on housing rather than community services.

Like the MHA, the Mental Retardation Administration (MRA) also looks upon deinstitutionalization as part of the continuum of care concept. Within this framework, its objective is to help retarded people to live in the most unrestrictive environment they can manage. To implement this objective, MRA first plans to make community services available. These services are to be not only located in the community, but provided by community sources. To stimulate the development of these services, MRA has divided the State into six continuum of care areas, each of which has a field staff. This staff is supposed to work with local communities to plan for its needs, to make the community aware of its problems and to help develop community programs. Much of the impetus for this community approach stems from court decisions proclaiming civil rights for the handicapped and the insistence of interested groups, such as the Maryland Association for Retarded Citizens, who are concerned about the quality and the availability of services for the handicapped children.

The second priority of MRA is to deinstitutionalize and to provide institutional reform. At present, deinstitutionalization or depopulation is hampered by the lack of community services. The emphasis on institutional reforms is particularly important since

many MRA institutions have lost accreditation and are threatened with loss of Federal reimbursements.

The Juvenile Services Administration (JSA) has been implementing a deinstitutionalization policy since the late sixties when it was first established as an independent agency. Since becoming part of DHMH, its policies have not changed, and they are consistent with the overall goals of the Department.

For its next five-year program, JSA plans to continue emphasizing treatment of the child in his home. By 1981, they project that 80% of those children who come to the attention of JSA will be kept in the home; in 1974 only 23.7% were so placed. To implement this objective, JSA plans to purchase support services to help the child and family. The kind, level and nature of support services and the funds available are not fully detailed in their plan; they are budgeted at $441,600 for FY 1976 and $384,000 for FY 1977.

Of the remaining 20% brought to the attention of JSA, 15% will be placed within the broad network of group homes JSA has at its disposal. While this would be a reduction in the number of youngsters now served in group homes, the workability of the approach is dependent upon the success of family care and the availability of support services. In view of the funding trends, it seems likely that sufficient funds will not be available to implement the program concept on the scale envisioned by the agency. Therefore, it appears that there will be a continuing need for group homes.

JSA estimates that the remaining 5% will be referred to JSA institutions. JSA has a diverse institutional capability consisting of training schools and forestry camps and is proposing a maximum

security facility for juveniles. As a last resort, youngsters will be cared for and treated in the institutions most appropriate to his or her behavior and rehabilitation needs.

The JSA community approach also includes a sheltered care component. This facility or individual home would provide temporary, non-secure placement during the pre- and post-trial period, the latter for a youngster awaiting permanent placement. Twenty-four hour supervision would be provided and it would receive difficult youngsters who could not be placed in their homes during the interim period but were not in need of secure detention.

The deinstitutionalization effort of JSA also has a prevention arm in the Youth Service Bureaus (YSB). The YSB's are walk-in, non-coercive counseling centers which act as mini-mental health centers for children and adolescents who are experiencing problems. The bureaus also claim to be community change agents, whose objectives are to modify those institutions and relationships that cause problems to young people as a class. They have considerable community and political acceptance and appear to operate somewhat independently of other JSA programs.

YSB's were started with LEAA, OEO, and Model Cities funds and have received continual funding from JSA. Because of budget constraints, local jurisdictions may be asked to pick up a percentage of the costs of these YSB's.

JSA also offers long term specialized foster care in lieu of post-institutional placement. In addition, a great deal of pre-court diversion into formal and informal programs is provided which diverts over 50% of all youth referred. A day treatment program, the

Youth Service Center in Baltimore City, is an alternative to institutionalization as is the Baltimore City Intensive Probation Program which offers intensive counseling, supervision, and a multi-discipline approach to youth who commit serious felony offenses.

Drug abusers have traditionally been institutionalized in hospitals or jails for treatment and rehabilitation. The Drug Abuse Administration (DAA) is committed to diverting drug abusers from these institutions where it is felt they get inappropriate care or no treatment at all. The main thrust of DAA's deinstitutionalization program is outpatient counseling. Approximately 48 programs have been established, most of which are operated by private non-profit agencies. In rural areas, the local health department provides the service. These outpatient programs are complemented by 5-6 residential facilities which house anywhere from 30-50 clients and often require a treatment period of one to two years.

Within the next five years, DAA efforts will be aimed at evaluating their existing programs. DAA also hopes to expand services since it estimates 100,000 drug abusers are going without treatment. However, they have no phased plans for additions or any assurance of funds.

The Developmental Disabilities Council (DDC) is a creature of the Federal government and is the only agency that stated that its deinstitutionalization policy was created in direct response to a federal directive to reduce the institutional caseload. In so doing, it is funding projects which will provide a comprehensive

array of services in the community. DDC intends to further the goal of deinstitutionalization in two ways. First, the organizational goals of the Council include four priority areas. These are community based programs/alternatives, institutional reform, legal and human rights, and development of a data system. Additionally, the Council directly funds projects such as providing continuum of care teams to staff community programs, or funding programs to aid sheltered workshop employees find independent living situations.

The Department of Human Resources (DHR), formerly the Department of Employment and Social Services, has a twofold responsibility for deinstitutionalization: it provides protective services for children and supportive services in the community for people who are eligible and in need. The nature of this child care has undergone a change in the last decade. As with other State-provided human services, institutionalization and custodial care is no longer acceptable. Now it is believed that children should not be isolated from the community but should be housed and cared for within it.

Within the Social Services Administration (SSA), child care services are provided for those children who are dependent, neglected or abused and who come to the attention of the Department. The JSA, which has been discussed earlier, has similar responsibilities except that youngsters under its protection may also have committed some illegal act. Many times, these agencies share responsibility for a youngster. If JSA feels that one of its wards can be better treated in an SSA facility, it can ask that agency for assistance in placing older children who come to their attention. Generally, foster care families are reluctant to accept responsibility

for a teenager and the agency has few placements available in its child care facility. There is difficulty in locating placements because the rates the agency is permitted to pay do not cover all costs. Occasionally, SSA will ask JSA for assistance in finding a suitable placement.

To meet these needs, SSA licenses a variety of community living arrangements. Foster care homes are available. These are homes for no more than six under age 18, including the family's own natural children and where the foster parents provide care in their family residence. Normally, foster care homes do not arouse controversy with the community. One of the major reasons for this acceptance could lie in the fact that many adults who become foster care parents are homeowners and longstanding members of a given neighborhood. Therefore, they cannot be accused of being "outsiders." Moreover, the number of children residing in a foster home is usually limited and the community feels assured that the children are going to be supervised by someone they know and perhaps respect. A third reason for the acceptance of foster care may be that the community gives a measure of respect to those families who open their homes to care for children who are in need of supervision, love and guidance. The fact that society considers this to be a charitable act could neutralize any resistance that foster care might arouse.

A "child care institution", as defined by SSA, appears to be similar to a JSA group home, except that in the SSA facilities there is no upper limit on the number of children who can be treated; regulations permit care for eight children or more. Proper safeguards insure a formal program of counseling, medical, recreational

and other services and the necessary staff to support the program in operation. Unlike JSA homes, it appears the SSA institutions have a greater capacity to be self-sufficient although few of them are because of the Departmental emphasis on community interaction.

Child care institutions have the authority to establish satellite group homes in a single dwelling or apartment which can accommodate between 4-12 children and provide houseparents or counselors. Group homes depend on the institution for ancillary services. Currently, there are 60 institutions and group homes; there is no plan which projects the number of facilities needed. Like JSA, SSA depends on the initiative of the private sector in providing the service.

SSA also has an indirect role in deinstitutionalization because of its responsibility to provide public social services. The local Social Services Departments are supposed to provide services that will develop the potential of individuals for eventual self-support, self-sufficiency and independent living. These services are to be provided to eligible clients, some of whom may have been released from, or at risk of being admitted to, an institution. These services include rehabilitation and health services, community home care and home health services, services to adults in nursing homes and purchase of care living arrangements for certain adults at risk.

In responding to deinstitutionalization policies, it appears that the Bureau of Social Services has chosen to concentrate on preventing the institutionalization of the elderly rather than other, or a mix of, target groups. In addition, it appears to have given little attention to the influx of formerly institutionalized persons into the community and the role it should play in meeting their needs.

At present, institutional barriers appear to exist which make it difficult for a recently released patient to receive services from the public social services agencies. Little pre-release planning is conducted for the individual. Therefore, institutional staff do not prepare a plan of services for the individual and do not help the person identify service delivery sources. As a result, no contact is made with the local social service agency. It should be noted that social service agencies and institutional staff do not frequently attempt to coordinate on the release of patients into the community. Unless the ex-patient has knowledge of the agency and presents himself or herself to the staff, they have no way of knowing his or her needs.

Within the Employment Security Administration, the Employment Service (ES) is responsible for meeting the employment needs of all residents of Maryland. This mandate presumably extends to those released from hospitals, jails and other institutions. Since employment is so often an important factor in rehabilitation, employment assistance would be particularly helpful to formerly institutionalized persons. Many deinstitutionalized persons are unable to find jobs because they are not properly trained after the long years of confinement. In addition, they often face discrimination in employment because of the stigma attached to confinement and institutionalization.

However, it appears that ES is setting new policies which could unfavorably affect the deinstitutionalized population. ES has been emphasizing assistance to the disadvantaged and the underemployed, with special emphasis on veterans and the handicapped. As a result of dealing with these difficult groups, there were fewer placements and

especially serious problems with employer relations, counseling and training services, all of which adversely affected the success rate of the agency. In response to this experience, the federal Department of Labor reduced its funding to the agency, whereupon several staff positions had to be terminated.

In response to this pressure for "success," ES has chosen a new emphasis. The staff is expecting to shift attention from the disadvantaged and non-job ready to job-ready applicants — those previously employed, those with jobs that are obsolete due to automation and mechanization, those living in remote areas who lack opportunity or who need to know about opportunities, persons retired or seeking a second career. Comprehensive Employment and Training Act (CETA) sponsors will become responsible for the underemployed and disadvantaged.

Although CETA has not been formally charged with the specific responsibility of serving the employment needs of the deinstitutionalized, it appears that CETA programs in the State may have the potential for helping to address some of these needs.

For instance, CETA currently funds a Comprehensive Offender Model Program (COMP). COMP offers job counseling, job development, placement and supportive services to men and women upon release from State correctional instituions. In addition, some walk-in clients, who may be involved at any point in the criminal justice system, may be accommodated.

The COMP program is currently being phased out and will be succeeded by the Maryland Model Ex-Offender Program (MEP). The MEP program will differ from the COMP program in that it will provide more comprehensive and concentrated services to a limited number of clients. Counseling, training, job development, placement, on-the-job follow through

services, and a variety of supportive services will be offered to 750 inmates and released ex-offenders during the initial 18 months of the program's operation. Staff training for this project began in October of 1975, with actual service delivery to follow as soon thereafter as possible.

A CETA staff member in the State Manpower Planning Office indicates that there is an expectation for continued and increased support for ex-offender programs. CETA legislation specifically mentions ex-offenders as an appropriate target group for CETA funding.

CETA staff in the State Manpower Planning Office also indicate an interest in the development of programs to aid entry or reentry into the larbor market by JSA clients and persons released from DHMH facilities, including persons suffering from alcoholism. There is also some interest in developing programs to aid labor market entry of the deaf and blind.

When the State Manpower Planning Office acquires sufficient administrative staff, they will consider adopting the procedure of sending out RFP's to all State agencies. Even with their current staff limitations, they express a willingness to consider any proposals for programs designed to meet the employment needs of target groups permitted under CETA legislation. It would appear that deinstitutionalized persons would in most cases be subsumed under CETA target population categories.

The perspective of the agency also appears to be changing with regard to its view of the needs of the employer. ES is intent upon strengthening relations with the business community. In reestablishing credibility with this sector, through the provision of job development services, ES hopes to increase its lagging job opportunities roster.

While these new trends may help strengthen the ES, it is unclear how the changes will assist the deinstitutionalized population in becoming independent through the provision of the more necessary services, job training and placement.

The Maryland State Department of Education (MSDE) is a regulatory and consultative agency and has no institutions under its control. It provides no direct educational service to Maryland children as this responsibility has been delegated to the local education agencies (LEA). Therefore, MSDE is not directly involved in the deinstitutionalization of a target group.

However, MSDE has been affected by judicial and legislative decisions which have required the deinstitutionalization of educational programs for handicapped children. In the case of the Maryland Association of Retarded Citizens vs. State of Maryland, the State was given the responsibility of providing free education for every handicapped child of school age regardless of the severity of the handicap. The State must comply with the decision for the 75-76 school year. Concurrent with this court decision, S.B. 649 was passed in 1973, which refined and extended the MARC decision by placing specific responsibility upon the LEA's to provide the educational services. It also expanded the client group to include all children between the ages of 0-20 years. To meet these responsibilities, LEA's have to present to the MSDE for approval a five-year plan for appropriate education programs.

Prior to these changes, handicapped children were educated by the public schools, by the State health institutions, particularly the Mental Retardation Administration, and by private programs financed by the family. In short, there was no systematic approach to the

education of handicapped children. As a result of the legislative and judicial pronouncements, deinstitutionalization does not mean prevention, diversion or release from an institution. Rather, to the educational institutions it connotes the shift in responsibility to the LEA's for the education of handicapped children in a variety of settings, the public school, day care programs or institutions.

As a result of these new public policies, the MSDE has changed its organizational structure to reflect an increased emphasis and expertise on the needs of the handicapped. However, the Department cautions that the new policies will have significant financial ramifications on the educational system and has deferred to the gubernatorial task force on educating the handicapped for recommendations on the level of funding needed to meet the new mandate.

Despite the concern over adequate funds, each of the four functional areas within MSDE, program support services, educational programs, public library programs, and vocational rehabilitation, seem to be responding to the new public mandate to give the handicapped equal opportunity and access to programs.

Program Support Services is particularly involved in planning for the transportation needs of the handicapped students over the next ten years; it is stated that transportation services to this group will be expanded, that new services will be developed and that standards for the transportation of the handicapped, as well as for pre-kindergartners, will be established.

The Educational Programs (EP) activity over the next several years will be to meet the legislative mandate of insuring appropriate and comprehensive programming for all handicapped children by 1980. MSDE

estimates that the number of handicapped persons served will increase from the 40,000 in 1965 and 88,000 in 1975 to 100,000 in 1981. Of the 175,815 students enrolled in vocational technical education, some 5,000 are handicapped. No doubt this figure will increase substantially by 1981.

One of the major EP goals is early identification of all handicapped children and youth through the Special Services Information System in order to provide them with specialized programs and services to meet specific needs. Training of teachers, paraprofessionals, parents and other community groups will involve a significant amount of energy. There is also emphasis on evaluating the cost and quality of in-State and out-of-State programs for the handicapped.

The trend toward smaller institutions and community-based rehabilitation and educational programs for at risk groups places new demands on community libraries to meet the needs of these groups. The Public Library Program is assisting community libraries in collecting and providing information on the services which exist within the community to help people. This information would be of assistance to staff planning for deinstitutional programs and for the affected clients. Further, there is an attempt to change libraries within institutions to better prepare clients for release. Another trend is to bring the community into the institution by relying on the public library to serve the institutionalized population.

Because of new Federal requirements, priority must be given to the severely disabled in the provision of Vocational Rehabilitation services. Greater costs and a longer treatment time are necessary for the treatment of this group. Therefore, in the immediate future, MSDE

projects that the total number of rehabilitated persons will decrease while the number of severely disabled rehabilitated will increase by ten percent. The Division of Vocational Rehabilitation maintains a vocational rehabilitation unit at each of the mental hospitals and Rosewood. The units strive to get the clients out of the institutions and also serve day clients, thereby preventing their institutionalization. Bus transportation to and from the institution is provided by the Agency. Two rehabilitation homes in Baltimore City are provided for the mentally retarded clients from Rosewood and also the community.

Major goals of the Office on Aging (OA) relate to deinstitutionalization. The agency hopes to increase independent living, to minimize inappropriate institutionalization and to provide a dignified level of living for those requiring institutionalization.

Despite the commitment to three goals, deinstitutionalization efforts seem to focus on the first goal, keeping the elderly, those who are self-sufficient and semi-disabled, out of, rather than releasing them from, institutions. This preventive strategy is to be accomplished by providing community-based supportive services which the elderly can no longer provide for themselves. Such services would include community home care, day care, housing, transportation, nutrition and income support, Geriatric Evaluation Services (GES), information and referral, education and employment. In many of these plans, particularly those relating to its proposed long term care system, it appears the agency intends to expand its role by providing direct services to the elderly population. It is not clear how these new responsibilities will be implemented and coordinated with units within DHR and DHMH which now have primary responsibility for this function.

Within this scope of activity, the Office is giving very high priority in its funding and activities to sheltered housing. Sheltered housing is seen as an alternative to institutionalization by decreasing the pressure for nursing home beds. Sheltered housing is being developed in conjunction with the Department of Economic and Community Development. OA must determine the number of units needed, priorities, admission standards, the system of rent subsidies and rent subsidy payments. Another alternative to care in large institutions is domiciliary care; this type of service is being studied by OA as part of a legislative mandate to develop a statewide plan for domiciliary care.

It should be noted that OA may be exercising increasing influence over the community activities of other agencies in the future. OA must "pass through" funds to DHMH for day care and GES, to DHR for community home care, public assistance and SSI supplements and to the Commission on Aging for nutrition projects. Recent action by the legislature increases the authority of OA over these funds. Instead of simply passing the money along, OA must now develop policy positions with which the above programs must be consistent. It is not yet clear how this new authority will be implemented.

The Department of Public Safety and Correctional Services (DPSCS) also responded to a Federal directive to deinstitutionalize. The impetus came from a 1967 Michaelson Committee recommendation to pursue community based corrections. This was followd, in 1970, with the appointment by the Governor of a Community Corrections Committee within the Governor's Commission on Law Enforcement and the Administration of Justice to study and develop a comprehensive plan for community corrections in Maryland. A Task Force in the Division of Corrections was created in 1971 under a

Federal grant by the Law Enforcement Assistance Administration to program and implement the recommendations contained in the Plan. Recently, planning and operating responsibilities for community corrections were separated, with the Task Force being transferred to the Office of the Secretary of DPSCS; the organizational location of community corrections within the Division of Corrections has not been fully determined.

In theory, community corrections is not new, but is based upon similar principles underlying such earlier correctional concepts as probation, parole, and work release. It may generally be defined as a rehabilitation process by which the criminal offender is reintegrated into the society through maximum utilization of local community institutions and services. In applying the community corrections rehabilitation process, a treatment program making use of resources available within the community is developed that is tailored to the needs of the individual offender.

Unlike other deinstitutionalization concepts, community corrections involves the community in reforming the conduct of criminal offenders. The emphasis in community correction philosophy is upon the community's role in providing treatment services, job opportunities and constructive life experience so that in effect the community bears some of the responsibility for the rehabilitation of offenders. Hence, community corrections becomes a vehicle for fostering a more positive relationship between society and violators of its laws.

Many different programmatic definitions have emerged in the effort to implement community corrections. In some states, the definition has been interpreted to mean a transfer in the level of governmental responsibility. Within this focus, it has meant the broadening and

strengthening of local jail systems to include post-trial custody of minimum security prisoners as well as the more usual function of pre-trial detention in order to relieve the burden on State penal facilities. In other states, community corrections has been defined as a form of decentralizationalization in which governmental responsibility is mixed with operation of centers being either a state function, or a matter of local option to assume control. In the State of Maryland, it has been defined to mean the development of a network of community based facilities preferably under local control. Centers are planned as prefabricated units able to house 72 or 108 inmates in two or three modules of 36 people each. Conceptually, "community" is defined as each of the state's 24 subdivisions. However, in practice, location of the centers is being determined by the geographic origin of offenders. Because of this orientation towards higher crime areas, a concentration of several centers is planned for Baltimore City, while most urban counties will receive one such center. In more rural counties with less population and crime, it is anticipated that several counties will be served by one regional center.

Two kinds of offenders are to be housed in Community Corrections Centers. First, persons will be received who are being diverted from the State's institutional corrections system as either first offenders or offenders determined to constitute minimal risks to public safety. Secondly, inmates from correctional institutions within six months of parole or mandatory release will be eligible for Center placement on a pre-release status. It is expected that the length of time to be spent in the Centers will range from six to ten months, making community corrections an essentially short term rehabilitation program.

During its implementation phase, Maryland's community corrections program has had a slow start. A major problem encountered by the Task Force has been a State statutory provision requiring local approval of Center locations. Because of neighborhood opposition to site selection and a consequent failure to obtain local governmental approval for most sites, pragmatic necessity has dictated that community corrections adopt a hybrid form.* Progress has been made in setting up centers only where facilities have been located on State owned property or as adjuncts to existing correctional facilities. Of five community corrections centers presently in existence, several are either existing private or local facilities participating with DPSCS on a purchase of service basis or former State facilities converted to serve as centers.

Despite public criticism of community corrections at the level of specific site selection, in a more general context, the perceived benefits of a community corrections alternative to institutional incarceration are of a wide-ranging appeal. From a treatment perspective, community corrections is viewed as a more humane way of exercising supervision over selected offenders than imprisonment, while at the same time providing the best opportunity for a proper readjustment back into society. Arguments have also been made on an economic basis from the standpoint that community corrections is more cost effective. Savings are said to be realized in terms of both reduced costs for custody, and as a result of revenues generated by inmates, who, as productive citizens holding jobs, can pay room and board, taxes, family support, etc. Recently, community corrections has also been justified as the most feasible solution to the State's critical problem of overcrowding in existing

*The 1976 Session of the General Assembly has passed a bill that will allow the State to intervene and find sites for community corrections centers when local jurisdictions are unable to obtain an appropriate site.

correctional institutions. In May of 1975, 6,549 persons were under incarceration by the Division of Corrections, while the rated capacity of state correctional facilities (under standards of the American Corrections Association) is only 4,733 beds. Because of this severe population overload in State penal facilities, a backlog of prisoners in jails awaiting transfers to the State system has developed, resulting in overcrowded conditions at the local level as well. To relieve some of this population burden from the central correctional institutions, nine community corrections centers with a potential capacity of 972 beds are proposed for construction in FY 1979. However, delays of up to three years in finding appropriate sites for these centers have jeopardized these plans. As a consequence, the Division of Corrections is being increasingly forced to resort to emergency housing to offset the marked increase in incarcerated population. This action, taken out of necessity is recognized to be both more costly and temporary in its effect than the more long term solution afforded by community corrections.

A major dilemma, as yet unresolved, confronting Maryland's community corrections program is the question of how to win acceptance by the community. Community acceptance is essential both as a legal mandate to secure local approval of site locations in establishing centers, and as a practical necessity in terms of neighborhood support to insure program success. Some steps are being initiated in the 1976 legislative session to overcome this difficulty. A new problem is developing, however, which concerns assurance of adequate State funding for community corrections when federal funds for a facility expire.

B. Inventory of Community Facilities

In order to inventory community residences, each agency was asked to provide the names and addresses of the community residences for which it was responsible. As stated earlier, there is a great variation in the definition of these facilities, and, therefore, a standard definition was not created. Instead each agency was asked to identify those facilities that it would consider to fall within the general classification of community residences.

This inventory revealed that over 200 community residences exist within the State of Maryland. This figure can only be considered an estimate since the life span of many of these programs varies, some may be phasing out and others not listed may be ready to open. In addition, a closer, individual appraisal of each facility and program might indicate that it should not be included. Despite these considerations, the inventory does provide the first comprehensive look at the State's system of community residences.

The inventory and interviews with program personnel revealed that there is a little interagency coordination over the location of community residences. However, it appears that coordination might be helpful in two ways. First, community residences within the same area might be able to cooperate on common projects such as community education, staff training, or the ordering of supplies and materials, Second, awareness of location could help in preventing an individual community from being overloaded with facilities. It appears that such concentration can place a strain on community resources and community hospitality to such programs.

The following table presents a breakdown of the number of

COMMUNITY RESIDENCES INVENTORY

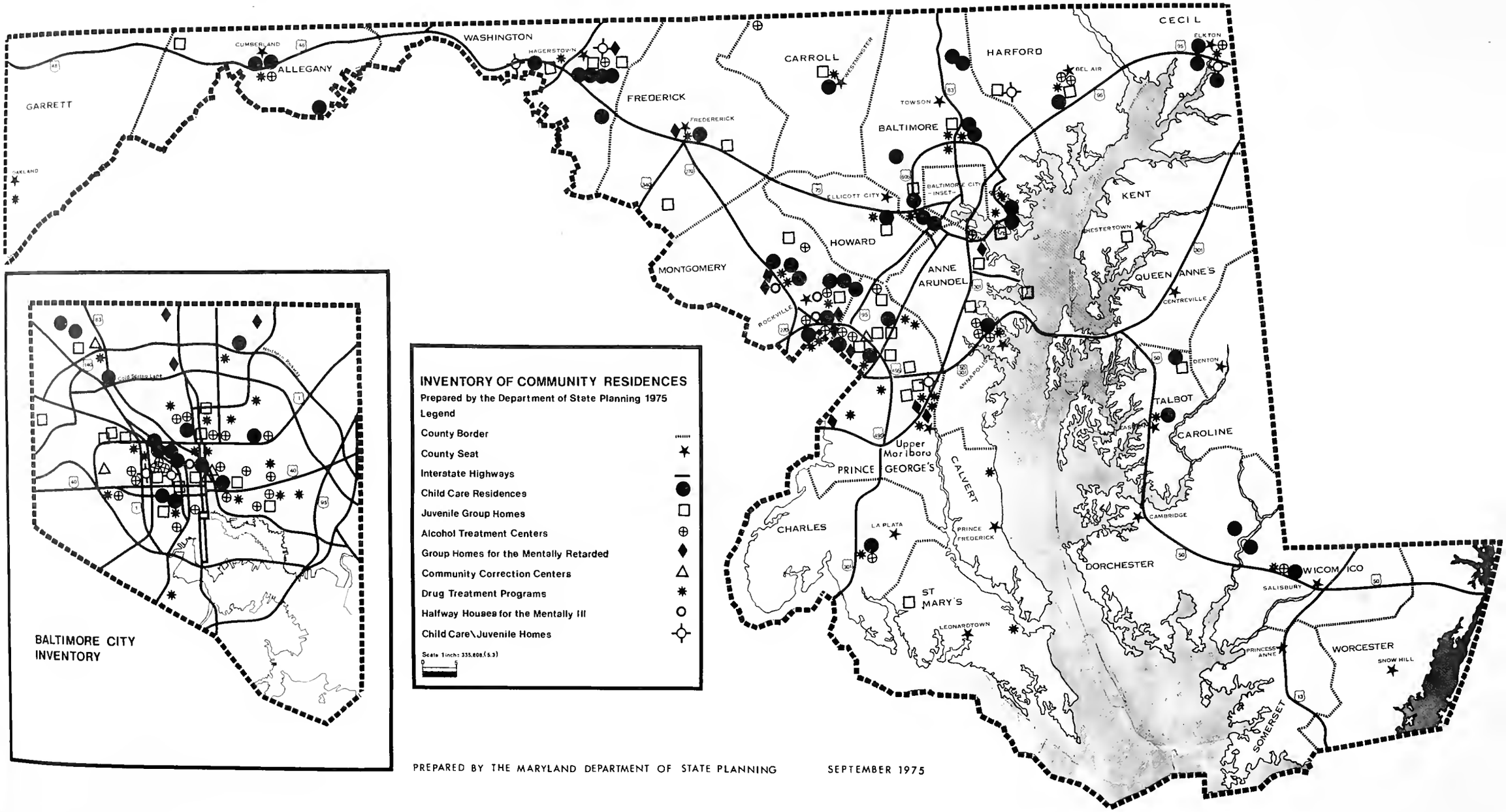
	Child Care Facilities (SSA)	Juvenile Group Homes (JSA)	Alcohol Treatment Quarterway & Halfway Houses	Mentally Retarded Homes	Community Correction Centers	Mentally Ill Halfway Houses	Drug Treatment Programs/ Residences	Joint Child Care-Juvenile Group Homes	TOTAL
Allegany	2	1	1	1					5
Anne Arundel	1	3	4	1					9
Baltimore City	15	11	20	5	4	1	17	2	76
Baltimore County	7	3		2			6		18
Calvert							1		1
Caroline									0
Carroll	1	1	1				1		4
Charles	1		1				1		3
Cecil	2	1					1	1	5
Dorchester	1								1
Frederick	1	2		1			1		5
Garrett	1	1					1		3
Howard	1	1					1		3
Harford	1	2	2				1	1	7
Kent		1							1
Montgomery	9	2	5	4		3	5		28
Prince George's	1	7	1	4	1		7	1	22
Queen Anne's									0
Somerset									0
St. Mary's		1					1		2
Talbot	2	1					1		4
Washington	4	3	1	1		1		2	12
Wicomico	2		1				1		4
Worcester									0
TOTAL	52	44	37	17	5	5	46	7	213

facilities sponsored by individual agencies for each county and Baltimore City. As will be noted from a study of the table, over one-third of the facilities are located in the Maryland suburban counties, Baltimore (7%), Montgomery (14%), and Prince George's (9%). The concentration of facilities in the most populous areas of the State would seem to indicate a direct correlation between population density and the need for community residences. However, this direct relationship is somewhat skewed by the fact that many facilities have been located in these jurisdictions, particularly Baltimore City and Montgomery County, because there has been less neighborhood resistance to contend with.

To some extent, the number of community residences in Baltimore County may not be an accurate representation of the need for such facilities in that jurisdiction. A county zoning ordinance prohibits the establishment of group homes for those subject to incarceration. Those in existence were either established before the ordinance was enacted or were properties of the State. As a result, many sponsors who wished to serve Baltimore County clients were foreed to set up community residences in neighboring counties.

Of the remaining community residences, approximately one-third are located throughout the rural areas of the State. Surprisingly, however, Washington County is host to 6% of the community residences in the State. Since the situation in this county has not been studied in depth, it is difficult to explain this phenomenon.

The map on the following page was developed to illustrate the distribution of community residences across the State. First, it will



INVENTORY OF COMMUNITY RESIDENCES

Prepared by the Department of State Planning 1975

Legend

- County Border
- County Seat
- Interstate Highways
- Child Care Residences
- Juvenile Group Homes
- Alcohol Treatment Centers
- Group Homes for the Mentally Retarded
- Community Correction Centers
- Drug Treatment Programs
- Halfway Houses for the Mentally Ill
- Child Care\Juvenile Homes

Scale 1 inch = 335,808 (5.3)

PREPARED BY THE MARYLAND DEPARTMENT OF STATE PLANNING SEPTEMBER 1975

be noted that by far the majority of community facilities provide services to children and youth. Second, from a review of the map, it appears that these facilities tend to cluster around the most "urban" of settings available to them. For example, in Baltimore City, most of the facilities are located in the downtown area, where presumably there is easy access to transportation and other community services. Even in the rural areas, there appears to be this same tendency. Most facilities are located in or near the county seats, the more densely settled places in each county.

IV.

Administrative and Policy Issues

It has become apparent that many problems occur during the implementation phase which serve to inhibit deinstitutionalization efforts. For discussion purposes, these problems are said to fall within the broad category of administration and policy. The General Accounting Office, in its study, is focusing on administrative and policy issues created by the Federal government which impede deinstitutionalization; this study emphasizes State-created administrative and policy problems that cause similar difficulties. Because of the anticipated similarity of both Federal and State problems, it is expected that the GAO study will serve to augment the findings of this report.

A. CONFLICTING STATE REGULATIONS

It appears that conflicts do exist among State regulations which could impede deinstitutionalization efforts. Because of time constraints, DSP did not conduct an exhaustive review of all agency and interagency regulations pertaining to deinstitutionalization and their impact on implementation. Instead, we highlighted the problem based on input from State program personnel which revealed troublesome

conflicts in program regulations. Undoubtedly, a thorough review of all relevant program statutes and regulations would produce a more comprehensive list of similar examples.

Regulation D: This State-passed regulation protects the civil rights of mental patients by preventing long term involuntary hospitalization. Under the regulation, a person cannot be involuntarily hospitalized for longer than five days. In order to be detained longer, the medical staff has to prove that the person satisfies three conditions: that he or she is mentally-ill, in need of inpatient service, and a danger to himself or herself or to the community.

As a result of this regulation, persons have had to be released without proper placement. As an example of the difficulties which arise because of this regulation, officials at the Mental Hygiene Administration reported the case of one young man who, immediately after release, was found outside the grounds hitchhiking to Pennsylvania to rejoin his family. Hospital staff reviewed his records and found that his family had long ago rejected him and wanted nothing further to do with him.

A new provision of Regulation D which has not yet been implemented, seeks to address this problem. It requires that before release, the patient must show that he can care for himself or at minimum, show that care is available. If these conditions cannot be met, the hospital authorities can continue to detain the individual.

Both Regulation D and the new provision set up conflicting problems for the mental health system. Often, persons must be released into a community which is not adequately prepared to house and care for them. As a result, their mental and physical health deteriorates

and they must be readmitted to the hospital. There, the cycle begins again. This pattern is often referred to as the "revolving door" syndrome. Under the new provision of Regulation D, the patient can be detained at the hospital; this amendment addresses the housing problem at the expense of civil rights. In addition, the inpatient population is not decreased and the goals of deinstitutionalization are thwarted.

MHA officials have suggested that a temporary shelter is needed to house expatients during the interim until they can get settled, or until a suitable placement can be found by the hospital staff. This kind of facility would also reduce the need for inpatient space.

Five-day Commitment Order: The revolving door pattern is also in evidence in the treatment of alcoholics. Under current law, courts can commit an alcoholic for five days of hospital treatment. During this period, the person undergoes detoxification and receives primary health care. This treatment does not include any rehabilitation service to help insure long term abstinence from alcohol, since the law does not permit the judge to require continuing outpatient care. Therefore, the alcoholic has to be released if he or she can no longer be helped by inpatient hospital care.

As a result of these procedures, many of the alcoholics never receive proper treatment and are returned repeatedly to the courts for commitment. DAC officials gave an example of one person who appeared before Judge Sweeney 115 times in 12 months.

It is evident that the process does not help rehabilitate the alcoholic. In addition, it also consumes precious court time. Efforts are now being made to relieve these conflicts by allowing the judge

to require enrollment in an aftercare program subsequent to the five day commitment.

Department of Human Resources Eligibility Requirements: To be eligible to receive Title IV-A public social services, certain Federal requirements must be met. In general, income eligibility requirements provide that public social services cannot be received unless the client is an applicant for or is currently receiving public welfare assistance. However, certain social services, such as alcoholism and drug treatment, mental retardation services, day care and family planning are exempt from this requirement. For this assistance, eligibility is broadened to include those who have been on public assistance in the past and those considered to be potential recipients.

Certain hospitals participating in alcohol treatment programs have had difficulty with this requirement. Through the Division of Alcohol Control in the DHMH, the DHR has made funds available for alcohol detoxification and treatment services in emergency rooms of certain general hospitals. During the intake procedure, personnel could document the fact of inebriation but because of the condition of the client, it was often difficult to document whether the person had received or was a potential recipient of welfare. In addition, since many alcoholics are transients, it was difficult to conduct any follow up investigation. As a result, many hospitals were denied reimbursement for the service. DHR felt that DAC and the hospitals had mismanaged the responsibility while DAC and the hospitals appeared to feel that the documentation requirement was onerous and unnecessary.

At first glance, it would appear that this difficulty has little to do with community residences. However, in the DAC community based

treatment system, the hospital is one of the major sources of referral for the community quarterway and halfway houses. In many cases, an intoxicated alcoholic will be taken to the large, general hospital for detoxification, after which he or she will be referred to a community facility. If hospitals refuse to treat alcoholics because of the difficulties experienced with the eligibility requirement, not only will many alcoholics be deprived of primary care, but they will not be diverted to community residences afterward for longer term rehabilitation and care.

With the implementation of the new federal Title XX regulations which have superseded the Title IV-A regulations for public social services, alcohol treatment will no longer be considered an exempt service. Thereafter, it may become more difficult for alcoholics to attain eligibility. Further study will have to be made of the effects of the new guidelines on many programs including alcohol treatment.

Facility Acquisition and Procurement Regulations: The amount of lead time needed to comply with government policies and regulations regarding the acquisition and procurement of real property is considered a major impediment to deinstitutionalization. Up to two years can be consumed in an effort to obtain State approval for a purchase. It can take up to 21 weeks for acquisition. During that time, in compliance with the Department of General Services' (DGS) regulations, two appraisals have to be made; if the asking price is too high, the project has to be dropped. If the price is within the range of the appraisals, negotiations can be entered into with the owner. Upon agreement, a contract is drawn up and sent to the Board of Public Works (BPW) for approval. In order to get BPW approval, the issue

has to be placed on the agenda, which takes two weeks of lead time. If renovation is being planned, it will normally take anywhere from 20-95 weeks for the architectural specifications to be written; 20 weeks if DHMH does the work; 43 weeks if a consulting architect is hired and 95 weeks if DGS assumes responsibility.

The time lag discourages private owners from selling appropriate properties to the State. In the private market, financing and acquisition would take about nine weeks and any renovation could be completed with 15 weeks. State officials feel that the State is simply not geared to operate in the private residential market; few private organizations or owners can afford to tie up their money for the two year length of the approval process. As a result, some officials have suggested that the State be able to offer an incentive to property owners such as a subsidy or bonus for tying up their property. Without such mechanisms, the State will be forced to abandon the private existing market and finance construction which in itself can require more time and more money.

Some agencies have tried to avoid the delays by renting apartments or houses. Unfortunately, however, the agencies cannot make an investment of their rental by entering into lease-purchase agreements. This type of transaction is prohibited since it requires a commitment of future funds.

A centralized procurement service has been created to coordinate group home acquisitions within the Department of Health and Mental Hygiene. It is expected that the centralization in itself may help to shorten some of the time requirements. In addition, however, the staff, along with DGS personnel, is now reviewing the State laws and

procedures to identify ways in which the process can be streamlined.

Right to Privacy: Because of its enormous capability and capacity to collect and store data on individuals and the potential and concern about abuse of this power, the Federal government has taken some steps to protect individual privacy, particularly of those who have received some assistance through government programs. Most generally, agencies within the Federal government do not permit personally identifying data to be collected about these individuals. Therefore, strict regulations are placed on the collection of data such as names, social security numbers and so on. In response to this Federal initiative, the State of Maryland has also enacted similar laws which safeguard the privacy of those individuals assisted by State programs.

While such laws and subsequent regulations and interpretations thereof do maintain the anonymity of the individual, they create difficulties for those who are concerned about program evaluation. An integral part of evaluation is to follow-up on those who have been assisted by the program and to make some determination about the relationship between subsequent condition and program effectiveness. Because of these privacy regulations, it is difficult for agencies to track down former participants.

For example, JSA has a data system to track youngsters who have been in the system. This system is severely limited since they cannot collect information on subsequent activity of an individual who is released from the system. Information can only be collected if that individual is readmitted into the system. Because of these limitations, the primary evaluative tool JSA has is the recidivism rate--a negative measurement. Unfortunately, to accompany these statistics, they have

no positive measurement of the experience of other releases, whether they have returned to school, become employed or exhibited less anti-social behavior. The use of other evaluative tools and methods is currently under exploration.

Without such data, it is difficult for JSA officials to evaluate their programs and report the results to other branches of the government. This problem is becoming more significant; increasingly, program officials are being called upon to justify their deinstitutionalization, as well as institutional, program approaches.

Life Safety and Other Codes: See page 106.

Others: According to the Medical Assistance Guidelines issued by the Medical Care Programs Administration, children residing in group homes are not automatically eligible for Medical Assistance payments. If their families are eligible for Medical Assistance, the child may be certified as eligible. Where the family is not eligible for Medical Assistance and is also unable to cover the cost of needed medical care, daily medical needs and expenses are expected to be covered by the facility. It is difficult, however, for facilities to gain sufficient funds to cover medical expenses.

B. CONFLICTING STATE POLICIES

Financial vs. Program Policy: The major policy conflict identified by State agencies is the gap between financial policy and program policy. A widespread feeling exists that broad policy mandates are initiated by the courts, the legislature or the executive branch, but that adequate funds are not subsequently provided to meet these new responsibilities. The issue of implementation is left to the operating agencies and, frequently, little guidance is provided on Statewide priorities. Many agencies compound this problem by not taking the

initiative to identify and establish priorities for the Legislature and the Executive to review. This issue will be discussed in greater depth in Section V.

Lack of Coordination: Another policy problem which exists is the lack of coordination between agencies on the development of their deinstitutionalization policies. Since no forum exists for the formulation of policies, there is no routinized consideration of the effects of one agency's deinstitutionalization policies on another. As a result of this practice, serious problems ensue since the deinstitutionalization policy of one agency often has direct consequences for a sister agency. For example, in order to be maintained in the community, patients released or being diverted from a mental hospital may need the services available from the local public social service agency. Without the coordination of MHA and SSA, it will be difficult to determine whether this deinstitutionalization policy is a realistic goal and whether it can be implemented given the available resources within each agency.

Although little coordination is evidenced at the policy formulation level, there appears to be some ad hoc coordination among agencies on the implementation or operational level. For example, apparently good coordination exists between DAA agencies and the criminal justice system participants. Each program manager is responsible for making contact with the courts in the area so that the judges will be able to make referrals to the program. In addition, there is close cooperation with the parole and probation officers who also refer people to the programs. There appears to be some cooperation with the local education agencies on the subject of drug education, but as will be

pointed out below, this cooperation leads to some confusion. Informal coordination also exists about the purchase of care rates, or in some agencies, about the disposition of a particular youngster. In addition, formal agreements exist; for example, between SSA and JSA, which outline shared responsibilities for certain children.

Clarification of Responsibility: One of the results of the lack of policy coordination is that some confusion exists among agencies that have overlapping or shared responsibilities for deinstitutionalization policies and programs.

An example of confusion or overlap in responsibility is that encountered by DAA programs with the Maryland State Department of Education and the local education agencies. Because of the drug problem in schools, many drug education classes are now being offered. However, counseling services which are badly needed, are not being provided by the guidance staffs. Therefore, DAA program managers have been asked to come into the schools to perform both counseling and education services. In some cases, DAA resources are so deeply involved in the educational system, that they are hardly able to operate their outpatient programs. DAA staff feel that they should not be directly involved in the schools, although they feel strongly that counseling services are needed. They would prefer to train guidance counselors to provide the services so that they can concentrate their efforts on helping the client who has no institutional supports and no resources.

Clearly the roles of the DAA programs and the local education agencies and their shared responsibilities have to be more sharply defined. Since both the drug and education programs operate

independently, DHMH and MSDE might have to take the lead in proposing alternatives.

DAA officials also report that the same kind of confusion exists over the responsibility for urine surveillance. This issue is complicated by the fact that insufficient funds are available for the surveillance. A person is often paroled or put on probation with the stipulation that he or she participates in a drug counseling program and remain drug free. According to Maryland law, in order to assure the parole and probation officers that the person is not taking drugs, urine tests have to be conducted three times a week. If these tests are not conducted and reported, the person could be reincarcerated.

No funds have been made available for urine surveillance to the DAA programs or to parole and probation officials. Managers of drug treatment programs in the community take responsibility for having the tests done, but try to obtain the money from clients for the testing, the costs of which are $10.00 a week. The problem can affect the operations of the community programs since, in some cases, the program will subsidize the costs from the budget if the client is unable to pay. While this may help prevent reincarceration, the action, particularly if it is repeated, jeopardizes what is certain to be an already marginal financial condition.

If no monies are provided, neither DAA nor Parole and Probation wants to have the responsibility for urine surveillance. Therefore, the responsibility gets shifted to the client or as a last resort to the community program budget, neither of which may be able to bear the costs. If public funds cannot be provided for urine surveillance,

it has been suggested that parole and probation requirements for testing be reduced to one a week, which is the frequency recommended in Federal guidelines.

Recently, DHR, MSDE, and DHMH began development of an agreement to implement the Raines' decision and the State law regarding the public education of handicapped children. This agreement is known as the Memorandum of Collaboration. In it, phasing of the implementation plan is outlined and each agency pledges its responsibility for a certain portion of the plan. Program officials have suggested that many of the administrative problems that would be encountered in any kind of interagency effort have been identified and resolved before creating any operational difficulties. This approach may offer agencies a model upon which other interagency tasks can be designed.

Judicial Decisions: At times, judicially determined policies also raise difficulties for program administrators. One such problem applies to the limitation of court orders for treatment. For example, with drug abusers or troublesome youth, the courts will generally refer the youngster for treatment to a drug counseling program or juvenile group home. Many program staff feel that these youngsters usually have serious family problems which will continue or resume despite the individual's treatment. These problems can cause the youngster continual or increased difficulty and, as a result, force him back into the DAA, JSA or criminal justice system, To avoid this problem, program personnel have suggested that the courts have legal authority to require or recommend treatment for other members of the family, or the family as a unit, as well as the client. Note the discussion on the five day commitment order for alcoholics as another example of

the limitation of court policies.

C. STAFFING PROBLEMS

Termination of State Employees: One of the significant ancillary issues regarding deinstitutionalization has been the impact on State workers. The potential termination of State employees has been fought by public service unions in other States in the country. In so doing, many deinstitutionalization efforts have been obstructed. It does not appear that this problem exists in Maryland, perhaps, largely because the State has a policy not to terminate its employees. In the event that a job is abolished, the agency is responsible for finding another placement for the person.

This policy has caused some difficulty for State agencies. For example, twenty State employees were left without jobs in the transfer of the education program at Boys' Village to the Prince George's County school district. Because the MHA had to insure employment, an additional $215,000 had to be added to its budget. After some negotiation, local school officials agreed to hire several individuals. The others have been retained by the agency or picked up by another State agency that could find a slot for the person. In another instance, MHA was more successful in that it negotiated with the local school district to pick up all the State employees.

The policy of insuring employment, while providing justice to the State employees, has significant implications for the financing of deinstitutionalization programs. As a result of the policy, dramatic savings are not realized initially by staff reductions when an agency begins to implement deinstitutionalization policies. Rather, the savings are realized over the long run as the number of employees is

gradually reduced by natural attrition, reassignment or retirement. Since many policy-makers believe that deinstitutionalization, ipso facto, produces savings through staff reductions, it is important to note that this is often difficult, if not impossible. If the responsible agency can convince a sister agency to absorb the salary costs, the drain on the tax dollar may be the same although one agency's budget may reveal a savings. Another danger occurs when individuals are reassigned within State government. Because only a certain amount of budgeted slots are available, a reassigned individual may be forced to take a job that does not effectively utilize his or her talents or experience. Then, a double loss can occur to the State: the individual may be less productive and funds and time must be expanded in a retraining process.

Transfer to Community Programs: Providing a local governmental agency decides to employ the State employees, other problems exist for the employee. First, since local salary scales may be different, the starting salary may not be the same. Second, fringe benefits such as retirement plans and health insurance may be terminated. Apparently, inordinate amounts of time have been spent by State program officials in efforts to help transferred employees retain retirement benefits.

Other problems result in the transfer of State employees to community programs. One between MSDE, MRA and the local education agencies involves employee certification. As a result of the Raines' decision, MSDE, through local education agencies, will be taking over many MRA day care centers in FY '77. There is the possibility that MRA day care teachers will be required to meet certification requirements as a result of LEA takeover, and that many will leave rather than

return to school to get a college degree. This issue will be particularl important during the transition period when MSDE is training public school teachers to work with the retarded. Some kind of amended credentials may be necessary to staff the programs during the interim or to keep on staff those teachers who have had successful experience in the MRA programs.

Some agencies have avoided these staffing problems by transferring State institutional staff to State community programs. For example, the number of staff in the Alcohol Rehabilitation Units in the State mental hospitals has been reduced from 112 to 95. Employees have transferred to the county mental health departments as alcohol counselors, and have not lost seniority, pensions, and so on because these county agencies are part of the State system. Therefore, county health employees receive the same benefits as their colleagues in the central office. Unfortunately, this same protection is not provided in the several home rule counties which have their own, independent local health departments. In addition to the State health programs, JSA has transferred some staff from the training schools to their community programs without having to deal with bureaucratic difficulties regarding employee benefits.

Contrary to popular belief, most program personnel report that they have few of the staffing problems mentioned, largely because they find they have no excess staff capacity. Many do not have to worry about transfer or termination because the additional staff is needed for compliance with accreditation standards. One program director reported that excess staff would be a problem if deinstitutionalization efforts were stepped up to the level of, for example, releasing half

the patients in a State mental hospital. Since he does not envision that this will occur, he does not feel the agency has to deal with the problem.

Staff Attitudes: For the most part, staff involved in deinstitutionalization programs are strongly committed to the concept. They feel that the programmatic emphasis in traditional institutions is unsatisfactory and that even if it were improved, the service capacity would not be sufficient to treat client/patients.

However, staff in some of the institutions have different attitudes about the concept. In some of the MRA institutions, it has been reported that some of the aides, who have been caring for the patients for many years, are protective and view deinstitutionalization as a threat. In addition, many have evinced serious concern about the future health of patients who are released into the community without adequate alternative living arrangements. This response is understandable in view of the close relationships that sometimes develop between staff and patients in these caregiving institutions. In general, however, these attitudes do not thwart deinstitutionalization except in those States where the public service union, the American Federation of State, County and Municipal Employees, has chosen to fight deinstitutionalization efforts because of its potential harmful effects on patient health and employee rights.

In some other cases, feelings and attitudes toward deinstitutionalization have been more hostile. One reason for the hostility relates to the concept of deinstitutionalization itself. For example, persons who have worked in the corrections field for many years have been trained to develop and provide custodial care. Because of this

background and emphasis, many are not enthusiastic about rehabilitation efforts which are an integral component of community corrections. As a result of this difference of opinion, two systems without any linkages could be created instead of one larger system that shares the strengths of both correctional approaches.

Since the two systems have not been fully integrated, operational difficulties may arise. The prisoner classification system could be one area in which these differences manifest themselves. Under this system, prisoners are classified as to their security status by institutional employees. Since only minimum security prisoners are eligible for community corrections, traditional employees can control the flow and type of person eligible for the program. It is argued that they are unduly restrictive in their classifications and that, as a result, community corrections staff never get the opportunity to screen many offenders who might be good candidates for the program. Further, since institutional employees may have a bias against rehabilitation, they are not likely to classify prisoners according to their potential or capacity for change.

In addition to substantive differences, another motive for resistance is self-interest. Many institutional personnel feel that deinstitutionalization threatens the existence of institutions. They feel that the community programs will drain off the most talented staff and the milder or less troublesome patients and clients. As a result, they will be left with the most difficult cases and the least capable staff. Any success which they could have claimed credit for will become the province of the community programs.

Despite these forays into self-interest, they are also raising the valid issue that the community approach is not good for all people. In so doing, they justify the continued existence of the institution.

Staff Skills and Training: Many institutional workers cannot be transferred to new community programs. Some are more interested in institutional work and others are not prepared to deal with the more flexible environment which exists in the community. However, those who evince an interest are usually given the opportunity to transfer, where this is possible.

It is likely, however, that as the Community Corrections Task Force has suggested, many employees in the institutions have lost their interest in innovation. For example, the task force analyzed employment patterns in the correctional system and found that employees exhibit a series of qualities which hinder experimentation: lack of involvement, lack of training, lack of interest or frustration from being pigeon-holed in a dead end job, little understanding of the corrections program as part of a larger system and little rapport with colleagues. Task force staff felt that these qualities would not be compatible with the environment in a community corrections center.

As a result of this study, new job description for a correctional specialist has been developed. The basis of the new position is to provide employees with changing responsibilities in the corrections field and with some kind of career ladder to maintain interest. The specialist will be required to perform on a rotating basis all kinds of duties, including administration, screening, general maintenance and purchasing, financial control, staff training and coordination, first aid and safety and resident employment.

Despite these efforts, in general, training of community residence workers is inadequate. Since no large pool of trained workers exists, many programs rely on young, inexperienced people who have just graduated from college. They have the necessary energy and will work for low wages. In addition, there is also uneven training among program managers. Most agencies have tried to deal with this problem by offering training programs, however, many agree these efforts are insufficient.

One of the reasons for the lack of trained staff is that few training programs exist for community care workers. Due to the intensity of the job responsibilities, for example, those that are trained, such as teaching parents, or those that are dedicated to the work, become exhausted and leave after one or two years. As a result, it is difficult for these talented people to pass on their knowledge and experience to succeeding generations of community workers.

Besides training, several other problems exist which make the profession unattractive. First, salaries are very low. (Some program officials reflect that the inadequate salaries are a symbol of the lack of value our society places on such employment.) Consequently, the field attracts less qualified people who do not have the capabilities to establish and administer a community program. Second, the field is in such a state of change that young professionals hesitate to devote time to it. The policy of deinstitutionalization needs to be stabilized with funds, training and continuing education programs and credibility; then it is

agreed, talented and capable people will be available to establish new programs.

D. REUSE OF BUILDINGS

There is widespread belief that buildings emptied by the deinstitutionalization process, can be reused for other purposes. Interviews revealed that in more cases than not, reuse is unlikely. The institutions under the auspices of MRA, provide a good illustration of this finding. It has been suggested by program personnel that there is little reuse capability for buildings vacated at Rosewood since they are so old. If other facilities, which are in better condition, are vacated in the future, they may be available for conversion to other uses.

Those facilities that will have excess space because of deinstitutionalization will need the space to meet new Federal regulations regarding life-space and safety. For example, recent life-space regulations require that only four residents be lodged in one room; this is a lower client/space ratio than is now in use. If community corrections is implemented in full scale, it is unlikely that excess space will be available since the jail facilities are presently overcrowded.

The MHA is now investigating the possibility of using space in State hospitals to set up adolescent wards. The investigation is taking place at Spring Grove and Springfield and is largely the result of the Montgomery County court case requiring separation of Montgomery County adolescents from adult wards.

V.

Financial Problems

The most immediate response of the State program officials to questions regarding implementation was the fact that insufficient funds existed to properly administer a deinstitutionalization program. This issue was touched on briefly in Section IV and will be discussed more fully below.

A. INADEQUATE FUNDING

There was significant agreement that sufficient funds are not made available to implement deinstitutionalization programs designed by the State agencies, the Legislature or other participants in State government. As earlier discussion points out, this problem is complicated by the lack of priorities established for the allocation of funds.

Experience with Article 2(c) provides a good case study of the problems that occur as a result of inadequate funding. The legislature passed Article 2(c) which decriminalizes public intoxication. However, adequate funds were never appropriated to provide alternate systems of care. Without an adequate network of community programs, law enforcement agents have little choice but to continue to place many public inebriates in jail, therefore, perpetuating a treatment approach that has been publicly repudiated. Change is occurring and more community programs are becoming available. However, the example illustrates the excessive lag that exists between the initiation of a new policy and its complete implementation.

The mental health system provides another example. The system is based on a policy of unitization which provides that all residents have the continuum of mental health services available within their own county. The conerstone of this system is the community mental health center which acts as the bridge between the hospital and the community. It provides services which prevent institutionalization and also provides aftercare services to patients who have been released from State mental hospitals. In so doing, the center is capable of controlling the flow of patients to the hospitals and maintaining those in need in the community. To buttress the work of the center, group living facilities are part of the system and are satellites of the center. Persons diverted from the institutions or patients released from the hospitals are referred to the facilities whereupon community mental health workers make contact with them and arrange for the delivery of services. Throughout the system, there is a close working relationship between hospital and community staffs so that patients do not get lost as they move through the continuum.

In reality, the system does not operate as efficiently and automatically as the theory and policy suggest. One of the main reasons is that the major component of the system, the community mental health center, is overtaxed, underfunded, and/or incapable of providing the range of mental health services needed in the community. The community staff concentrates on providing direct outpatient services and has insufficient resources to provide aftercare to those released from the hospitals.

Another problem with the system is that the number of group living arrangements is insufficient to meet the need. Currently, only two halfway houses exist and foster care homes are limited. As a result, many patients are released into the community without adequate living arrangements and supportive aftercare services. As a result of these deficiencies in the system, a great likelihood exists that the patient will regress and become reinstitutionalized. This revolving door pattern exists not because deinstitutionalization per se is an unworkable policy, but because funds have not been available to build in sufficient numbers the components of the system. Since linkages exist between the components in the continuum, the failure of one element to perform has ripple effects throughout the system.

Purchase of Care Rates: One cause of inadequate program budgets seems to be inadequate funding of purchase of care services. Both community residence sponsors and State program officials feel that the purchase of care rates are too low. Efforts to increase these rates have not been entirely successful.

The purchase of care approach appears to be the most economical from the State's point of view. If the State owns and operates a facility, a staff of five people is needed to operate and maintain the home because of limitations on the work week, leave policies and fringe benefits. If the State chooses to own a property and lease out the operations and functions, a minimum of two people are required, houseparents, to staff the house. While more staff may be needed, the level may not be as high as for a State operated residence. These individuals frequently do not receive the same level of benefits as State employees. Under this approach, the

State still has to expend resources to maintain the property but lease funds are designated for this purpose. In addition, the State would have no outlay of funds for purchase of the property or continued maintenance. Moreover, the lengthy acquisition process discussed in a previous section is avoided.

The Maryland Association of Residential Facilities for Youth (MARFY) is an organization of private child care sponsors. Privately, and through the association, many sponsors have expressed resentment over the inadequate purchase of care rate; they feel the State is exploiting their charities. Many sponsors have subsidized the rates by seeking and receiving contributions from the community. Others are threatening to, or have closed, their programs because of financial instability and potential bankruptcy.

In several cases of groups homes used by JSA, a 4 year cycle has emerged. In such cases, the first three years an LEAA grant is available to supplement JSA purchase of care funds. During the fourth year, these programs have declined and had to be closed because of lack of funds. This short life span is detrimental to the deinstitutionalization effort. First, staff efforts are dominated by starting programs and raising funds at the expense of providing treatment to the residents. Secondly, because of this erratic pattern, community residences can get a "fly-by-night" image which can only further complicate community acceptance efforts.

Several other issues have arisen about purchase of care. One relates to the occupancy rate in the house. If a 100% occupancy rate exists for the entire year, a budget can be drawn up that may provide all the funds necessary for operations. However, often 100%

occupancy does not exist. Many times a youngster will be transferred home, to another program or to a training school. That spot is often not filled immediately with another child. Although the monthly payment is not being received, fixed costs such as staff salaries and rent or mortgage payments continue. The longer or more frequent these vacancies, the more likely the facility will have to operate on a deficit budget. Because the budgets are marginal to begin with, given one emergency such as a major repair, the program could become insolvent. As stated earlier, those facilities that are operated through grants are in a better financial position since they can program the uncertainties into their budget.

Private sponsors also claim that the rates are inadequate to provide youngsters with necessary services. Many State officials reply that the rates become insufficient because program sponsors inevitably seek to expand programs and duplicate services that are already available in the community. Program sponsors claim that they must provide the services because they either do not exist in the community, are not available in the form the group can use, or regulations require that they provide the services themselves. For example, county mental health services are available from 9 A.M. to 5 P.M. on weekdays. If a youngster needs psychiatric counseling at any other time, he cannot rely on the community services. Therefore, program sponsors like to have on contract a psychologist or psychiatric social worker who would be available at any time of the day or night, depending on need.

MARFY members are particularly irked by the fact that State group homes cost out at $629 plus per month per child for operations

while private sponsors receive a montly rate of $600. Indeed, the variation between the rates is even greater since the costs of acquisition are not included in the rate for State run group homes. In contrast, private sponsors must cover acquisition or rent costs within their monthly care rates.

The State insists that its higher rate is justifiable because of State salaries, fringe benefits and limitations on the workday and workweek. Group home sponsors reject this explanation because in JSA guidelines they are urged to offer a wage scale and working conditions commensurate with that of the State. Currently, however, many of the employees are working for well below the minimum wage and without fringe benefits. Without this kind of sacrifice, they report that they would not even attempt to provide care at the current rate.

State program officials have their own problems with the purchase of care system. First, many believe that the rates should reflect regional differences, i.e., the cost of living in Montgomery County is far greater than in rural counties on the Eastern Shore. Second, many complain about the excess rate guidelines. In some cases, a higher purchase of care rate can be made available for special services. However, after the decision is made by the program staff, it has to be reviewed by the Department of Budget and Fiscal Planning (DBFP). There is some feeling that DBFP is far too demanding in its request for justification of the excess rate. Further, program personnel feel that they have the expertise when prescribing client services and that this expertise cannot be duplicated by a financial analyst or accountant.

Some State program officials also have expressed concern about their inability to jointly fund services. Under such a system, several agencies could pool purchase of care payments to increase the payment per client. For example, SSA and JSA would jointly diagnose a child and pool resources so that perhaps $1,000 per month would be available for tuition in a special program. This practice has been prohibited by DBFP, apparently because of the need to protect the purchase of care fund from double-billing. Although joint funding did not solve the general dilemma of the inadequate rates, it by-passed for a time the limitations to dealing with the exceptional child.

Other program officials object that they have no purchase of care authority at all. For example, in MHA, little purchase of care money is available, largely because MHA has caregiving capability in its institutions. However, it is felt that these institutions in many cases do not provide sufficient flexibility in treating young children and adolescents. In order to provide more appropriate services, often the mentally ill youngster is diagnosed in such a way that he or she will become a ward of JSA or SSA, agencies which have purchase of care authority. While this procedure accomplishes the objective of getting treatment services, it raises the possibility that the most appropriate treatment or placement might not be secured.

State officials claim that the purchase of care rates are inadequate because they are based on a common denominator rather than on the actual needs of the child or program. For example, if

a sponsor advises his insurance company that foster care children are living in his or her home, insurace rates will increase. Purchase of care rates do not take such a cost into consideration. Therefore, they create a disincentive for individuals to participate. In addition, since different purchase of care rates exist among agencies, it is alleged that competition is created among care-holders for those clients with a higher monthly allowance.

Both State officials and program sponsors have actively pursued efforts to change the purchase of care system. They claim it is a hodgepodge system based on piecemeal changes. Furthermore, the changes are more of a response to the constant pressure to increase rates rather than a comprehensive understanding of the services that are needed. Some of the agencies have participated in seminars on the subject and both groups urge that the system be thoroughly studied.

Cash Flow Problems: As stated earlier, most community residences operate on marginal budgets. A cash flow problem is created when there is a time lag between submission of vouchers and reimbursement from the State or in the receipt of Supplemental Security Income (SSI) checks. In order to ease the cash flow problem which results, it has been suggested that a revolving account be established to pay the sponsors during the interim.

B. RELIANCE UPON FEDERAL FUNDING

Many deinstitutional programs in the State of Maryland are funded exclusively or in large part by the Federal government. Drug and Alcohol programs are largely funded with Federal funds. LEAA has given three-year funding to the DPSCS for community corrections and

through JSA for the development of group homes. The Federal Department of Health, Education and Welfare makes funds available to those school districts providing educational services to handicapped children being released from an institution.

While Federal funding solves an immediate financial problem, it has long term implications. Due to Federal financial contributions, State officials may not be fully cognizant of the financial magnitude of deinstitutionalization. Therefore, when Federal funds terminate or less funds are available on a continuing basis, the State may be incapable of providing continuing funds at the same level for these Federally-inspired programs. On the other hand, the State may be forced to pick up the costs of a program because of the strength of its proponents rather than because of its quality and the utility of the program to the entire system.

C. DISPARATE STATE FUNDING

Some State-sponsored deinstitutionalization programs seem to enjoy greater solvency than others. For example, MRA financing arrangements are very attractive to potential group home sponsors. MRA picks up 50% of the construction costs and then permits mortgage costs to be included in the operating budget. Sponsors own the property and have a ten-year contract with MRA to operate the home. After the ten-year period, the contract can be renewed. MHA, on the other hand, appears to be in a less attractive financial position. Its request to fund several more halfway houses for patients released from mental hospitals has been rejected. It is not clear why these disparities exist.

As another example, MRA group homes are funded on a grant basis. All operating and program expenses for the entire year are budgeted and the sponsor receives a grant for these annual costs. Group homes used by SSA and JSA are funded through purchase of care arrangements which provide the sponsor with a monthly allotment for each youngster residing in the home. This latter approach is apparently less satisfactory since the budget is tied to the occupancy rate rather than to the kind and level of program and services that should be provided. It also permits much less flexibility in budgeting - a flexibility which is cherished by program sponsors.

D. NEED FOR CONCURRENT FUNDING

Most agencies with large capital investments such as MHA, MRA and DPSCS have concurrent funding problems. These agencies have large extensive physical plants and need a considerable budget to maintain them. Some institutions, such as those under the jurisdiction of MRA, need more funds to maintain their buildings at a higher level for fewer patients because of more restrictive requirements for Federal reimbursement. At the same time, these same agencies require a budget to develop and provide community programs. Since these agencies are performing two functions simultaneously, maintaining an institutional and initiating a deinstitutional program, concurrent funding is needed to fulfill these responsibilities.

However, the budget authorities do not look with favor upon concurrent funding. They assume that if an agency is embarking on a community emphasis, it can reallocate funds from its alleged under-utilized institutional program. Unfortunately, these institutions are not necessarily under-utilized. Because of deinstitutionalization

many are now operating with favorable staff/client ratios. In addition, as stated above, institutional funds cannot be freed up easily because of the need to invest them in improvements to meet new Federal standards.

With the concurrent activities of winding down an institutional program and beginning a community program, there is a transitional period in which both activities must be funded. Once the equalibrium is reached and the community programs become a reality, it may be possible to reduce or stabilize funds for the institutional program depending on the needs of the inpatient population. Budget officials must become more aware of this need for increased funding during the initial period; otherwise, they place program officials in a hopeless situation with regard to funding.

E. FINANCIAL ALTERNATIVES

It appears that State agencies are in a dilemma as to how deinstitutionalization will be financed. As stated earlier, few agencies have met this issue head-on by proposing a clearcut plan to the legislative and executive branches. Instead, they continue to expend energy patching up the old programs and planning new ones to meet the needs of their clients.

In some cases, financial alternatives are being explored. For example, MSDE has recognized that sufficient funds do not now exist to implement its new responsibilities with regard to the education of handicapped children. The staff is relying on the Schifter Task Force, which was set up to deal with this issue, to develop financial alternatives. Others such as DAC have been exploring the potential of financing by private, third-party insurance plans. For example,

an insurance company which provides health insurance to a large group such as a union would be encouraged to reimburse costs incurred by one of its enrollees for outpatient care and treatment in a community-based alcohol facility.

VI.

Lack of Supportive Services

Services are needed in the community to support those people being diverted or released from institutions. Unfortunately, however, these services are often not available. In this study, emphasis has been placed on the identification of those specific supportive services needed to ease persons through the deinstitutionalization process.

A. TRANSITION SERVICES

A broad array of services are needed to assist patients or clients in their transition from institutional to community life.

Pre-release or discharge planning: One necessary service is pre-release or discharge planning which would re-orient the individual to the outside world. Currently, most departmental personnel agree that this service is minimally available because of lack of staff or because institutional staff are not prepared to provide this service. For example, institutional libraries, in conjunction with community libraries, could be in a position to offer information, discussions or seminars on transition to community life. However, members of the institutional staff appear not to be concerned about this problem or do not have the proper training to assume these responsibilities.

In addition to providing a reeducation on community living, discharge planning often also includes identification of services the individual will need in order to maintain himself or herself in the community and organizations or agencies the individual can contact

to secure these services. Because of staff shortages, these plans are also not made. However, officials have reported that even if substantial efforts were expended on this component of pre-release planning, it would be a relatively fruitless endeavor because of the lack of services. There is no assurance that the community organizations would be able to respond according to the pre-discharge plan.

Two promising developments within the Department of Public Safety and Correctional Services (DPSCS) address the issue of discharge planning. First, DPSCS is conducting a study to determine the informational needs of offenders. With this information, it is possible that more relevant planning to address the primary concerns of the offenders can be developed. The results of the study may take some of the guess work out of discharge planning and free up some staff time and energies for other tasks.

The second development, Mutual Agreement Programming (MAP), requires the direct involvement of the client in the pre-release planning process. MAP is specifically designed for offenders bound for community corrections centers. Each individual scheduled for release confers with a MAP coordinator, a counselor and the parole board to work out a personal plan of rehabilitation. The individual tries, with the assistance of these professionals, to accurately assess his or her problems, talents and interests and to develop a realistic program to improve his or her situation. Conditions and goals are set for the offender and the correctional system accepts responsibility for providing the needed services. Once all conditions and goals are achieved, the offender is immediately

paroled. If there is a breach in the contract by the offender or the system, the contract is renegotiated.

The MAP concept gives the offender some responsibility over the rehabilitation program and removes the threat of arbitrary action by the parole board. In addition, the offender is not rewarded for past behavior in an institution, which is the basis of parole, but is rewarded on the basis of the potential for future positive behavior in the community. The MAP process also gives the individual preparation for life in the community and a better understanding of the community resources available.

Placement services: In addition to providing little orientation to community life, only minimal residential placement services are available to the institutional population. Most program officials report that staff is inadequate to provide these placements. Efforts to secure more staff positions have not been successful. For example, a proposal included in the Mount Wilson hospital budget request for a staff person who would be responsibile for finding and monitoring community placements has been denied for two consecutive years.

Currently, the Mental Hygiene Administration (MHA) has a particular problem with referral and placement services. First, the central MHA office exercises little control over the placement services for State hospital patients. It has delegated this responsibility to each of the individual State hospital staffs and, as a result, each has developed an independent approach to the problem. It does not appear that MHA wishes to bear responsibility for or tamper with the placement activities of the State hospitals, perhaps because of the long tradition of independence of the State hospitals. Even if a

more active role was assumed, it has been suggested by agency officials that it would be very difficult to initiate and monitor any procedural reforms in the placement system.

Second, finding community placements is a difficult and time consuming task and, apparently, hospital staffs have little time to devote to the job. Therefore, they are trying to shift this responsibility to local health departments and community mental health centers. It is unclear whether these agencies have the resources to assume this responsibility. (This issue will be discussed in subsequent sections). Despite the "hands off" policy of the MHA with regard to placement activities, that office may have to step in if it develops that neither the hospital nor the local health and social services agencies can provide the kind of placement services needed.

Follow-up Services: Very few follow-up services exist for persons released from an institution. Once the individual is released, there is often no further contact between the person and the institutional staff. For example, in MHA, only those patients released to foster care receive follow-up; patients released into some kind of less supervised living arrangements do not. Nor do they receive follow-up from community mental health centers. The medical staff has no way of knowing of the health status of the individual, his or her adjustment to the outside world and whether or not needed supportive services are being received. Too often, the only contact occurs when the person is readmitted into the hospital in a deteriorated condition. In another agency, DPSCS, the high staff/client ratio in the parole and probation program diminishes the effectiveness of the follow-up service.

A by-product of this problem is that little information exists about the released patient who is not readmitted into the hospital. Not only are the whereabouts or the health of the individual not known, other vital information is also not available, such as the level and kind of social services received, linkage with "helping agencies", and the degree of rehabilitation sustained over a period of time. Because of this lack of information, it becomes difficult to evaluate the long term effects of the program on the client. For example, in the DAA, there is now no screening or follow-up on clients who have participated in the program. Therefore, program officials have no information with which to determine the success of a certain approach or program. Currently, however, research is being conducted to see what happens to those who apply for assistance and do or do not participate. A report should be available within two years.

B. COMMUNITY SERVICES

In order to be maintained in the community, extensive community support services are often needed by the client. These include adequate living arrangements, physical and mental health services, education, transportation, social services such as homemaker services, day care, family counseling, employment services, and so on. Many of these services will be discussed below.

Residential Placements: Among supportive services, the greatest need exists for appropriate housing. Virtually every agency expressed a pressing need for residential placements. Without adequate placements, the pace of deinstitutionalization slows or the reform becomes meaningless if those patients released or diverted from institutions are left, unprepared, to fend for themselves.

As stated in earlier sections, provision of residential care engenders serious community opposition. It is also considered to be an unprofitable venture. Therefore, many people are discouraged from becoming sponsors. In addition, it has been suggested by some State officials that it is now unfashionable to offer this kind of housing service in one's own home. People who might have taken in patients to make extra money can now earn money through other means.

Apparently, a greater need for residential placements exists for some client groups than others. For example, DHR has few placement opportunities in foster homes for boys 15 years of age and older. Foster families seem hesitant to take responsibility for older children. Released mental hospital patients also have a great need for community living arrangements. These individuals are sufficiently dependent not to need foster care, but not independent enough for unsupervised living. Only a handful of community residences exist for these clients.

Despite the lack of facilities, patients are continuing to be released from State mental institutions. As a result of the need for community placements, a network of unmonitored and perhaps unsafe boarding homes or domiciliary situations are being established. MHA has a policy of placing no more than three persons in one house because a home with four or more residents requires compliance with more stringent fire codes. They report, however, that other agencies cannot be prevented from placing people in the same home. It has been reported that in some cases, a total of up to 15 people has been placed in a given facility. Because Federal and/or State money is not provided to pick up the cost of medical or social services,

residents receive only room and board. A large number of these homes operate without licensure because of the expenses involved in meeting standards and/or because they are unknown to DHMH officials. As a result, the ex-patient reaps the grim benefits: an unsafe building with no backup of medical or social services to support the newly acquired independence.

Another result of the shortage is that existing programs are pressured to accept more clients than they are able to handle. For example, in MRA group homes, many program managers will accept children in a crisis situation. With the addition of more persons on a sporadic basis, the scheduling and management of the regular residents is thrown into disarray. Consequently, the program and atmosphere can begin to suffer.

The problem is likely to continue as more agencies begin to implement deinstitutionalization policies. For example, in the transition of responsibility for educating handicapped children, the local education agencies will have to come to grips with the need for residential placements. Space for educational programs will probably be available, particularly in those communities whose growth rate has slowed and who, consequently, have excess space in public schools. Some handicapped children, however, will need 24-hour care and for these individuals, residential placements will be needed.

Health and Social Services: After proper housing, health and social services are viewed as most necessary for the maintenance of the physically or mentally infirmed in the community. For the most

part, agencies rely on local health and social service departments to fulfill the responsibility. However, there appears to be no systematic way in which diverted or released clients are referred to these local agencies.

Some agencies are trying to reduce their dependence on these local government departments largely because they perceive that there is a stigma attached to public health and social services. As a result, they feel that many people will not take advantage of the services available. Consequently, for example, the MRA uses the services of a number of private advocacy and service delivery groups including the Association of Retarded Children, United Cerebral Palsy Organization, League of Crippled Children, Catholic Charities, and other agencies financed by private sources such as the United Way. These groups in turn, become persuasive advocates for MRA programs.

Persons being released to their own families or to foster care situations often need home health care. Such services are also needed for the non-institutional aged and semi-disabled.

Family counseling also appears to be a greatly needed service. The presence of a retarded or troubled child often creates severe stress which can threaten the life and stability of the family unit. It was felt by several State program officials that many children have been lost to institutions because family therapy and other community health programs have not been available in the past. With many agencies now emphasizing family care, this service becomes all the more essential.

A great need also exists for other mental health services, including drug and alcohol counseling for youngsters. Several State

officials reported that local health resources will provide services as long as the requests do not dominate their work. Apparently, they do not want to be in the position of exclusively serving clients from community residences. Furthermore, as stated earlier, they do not have the staff necessary to implement outreach efforts. One program official reported, however, that the hospital staff at the Eastern Shore State Hospital had been performing this outreach effort very effectively.

There appears to exist a great need for homemaker services. These services, provided by the county social services agency and others, mostly relate to housekeeping, errand running, shopping, personal care and other tasks. In the past, aged people, the housebound or those in an emergency situation were the major recipients of this care. Once again, with the emphasis on family care, it has been suggested that these services are needed by families who care for a physically, mentally or socially disabled family member. Such a service would, for example, provide parents and other family members with some guidance and assistance on how to handle a developmentally disabled or mentally ill child.

Closely related to this is the need for respite care. Respite care provides relief for a family caring for a disabled family member. In the case of children, the goal is to provide the same kind of services for a handicapped child that are available for the normal child. Baby-sitting services would be available for a short time if the parents wished to go away for a weekend. Temporary care would also be available for longer periods of time for family vacations. In the case of adults, such as alcoholics or the mentally ill, or

troublesome youths, the respite care system would also provide day care services. The services would be designed to give the family time to recoup strength.

For the developmentally disabled child, diagnostic and evaluation services are needed. Hopefully, through county health departments, children at risk can be identified early and treated during the first five years of life, when brain development is still occurring. To adequately evaluate the child, additional resources are needed in the health departments such as a social worker with a developmental background, child advocates, physical, occupational and speech therapists. In addition, monitoring of the child's development has to be conducted.

To make diagnostic evaluation services work, it is important to get the support of the medical community, particularly primary care physicians. Apparently, many physicians do not refer children at risk or those with developmental problems because they do not want to alarm families, are not familiar with the developmental disabilities and/or do not know any appropriate referrals for the patients.

Education Services: In general, group home personnel have had difficulty getting youngsters into local schools. This is particularly true in the case of a boy being released from a training school. There is general apprehension over the aggressive behavior; in addition, if the child is not from the county, an issue arises as to which jurisdiction or agency is financially responsible for the education services. At one point, Harford County was billing JSA for educating several Baltimore County youths who lived in Harford County group homes. These bills were in turn referred to MSDE.

Apparently, the issue has been resolved and the local education agencies (LEA's) must assume the financial responsibility regardless of the original home residence of the child.

Nevertheless, it has been alleged that some local school officials continue to be resentful of JSA youngsters. As an illustration, one group home sponsor reported that the misdemeanors of one boy were carefully documented in a dossier and prepared so that expulsion proceedings could be initiated. The sponsor explained that explusion from high school creates significantly more problems for the youngster. Most times, the sponsor will try to find some alternative means of providing education either through private tutors or enrollment in the equivalency and other compensatory courses offered at community colleges. Often, however, appropriate educational programs cannot be found. Due to these problems, group homes are forced into a position where they feel they must provide their own educational programs. The development of self-sufficiency or self-containment within the group home will be discussed below.

Other program officials report that special educational services are needed for some of the children who come into the SSA and JSA system. Local schools many times do not have the expertise to educate these children and other provisions must be made. The same problem exists for emotionally disturbed children.

Another great need, closely associated to education, is for leisure and recreation activities for these specialized groups. Before concluding this section, it is important to note that some agencies report little need for or do not recognize the importance of community services. In general, any support services needed are

provided by the program. For some programs, reliance upon the community may be for a specific service, rather than a generalized long term system of services to maintain the individual in the community.

Three programs, drug and alcohol treatment and community corrections fall into this category. DAA reports no great need for community resources. Staff feels that most of their clients are young and still have resources, family, school, firends, income, so that they are not dependent upon public sources for support. It is felt that they need one service -- counseling -- which is provided by DAA programs.

DAC staff state that community treatment "presupposes strengths on the part of the person"; therefore, they feel their clients are not in great need of supportive services. Like DAA, the only service DAC seems to require is alcohol counseling. For the provision of this service, they rely heavily upon the local health departments, each of which has alcoholism counselors on the staff.

There is also a need for an emergency transportation system to help transport alcoholics being released from hospitals, to pick up those who have left the community residence, others having acute episodes, or those needing access to services. Without this kind of transfer, many clients lose their way and never make it to the treatment centers. In order to avoid further public expenditure, it has been suggested that public safety vehicles be used for this purpose.

Community corrections staff expect that few services will be requested from the community in terms of health care or social services. However, they report specialized needs for job training and placements and access to transportation services.

C. INVENTORY OF COMMUNITY RESOURCES

Many State agencies and private sponsors rely heavily on public agencies to provide services in the community. Few explore available private services. As a result, when public services are not available there is a tendency to provide the service internally. For example, one group home manager in Harford County feels that many of his boys need vocational training. Unfortunately, Harford County public schools do not provide this service. Consequently, he wants to set up a vocational school on the grounds of his home. Likewise, in the field of community corrections, program staff have indicated a need to provide their own recreational services. If left to develop in this way, these facilities could become mini-institutions, as isolated from the community as the institutions they seek to reform.

One of the ways of preventing this self-sufficiency process is to be more fully aware of the services in the community; few State agency and group home operators are. As a result, many clients or patients are not linked up with an available service they may need. MRA has developed a relatively sophisticated method of inventorying community resources for the retarded. First, the State has been broken into six continuum of care districts. Within each district, there is a continuum of care team, with one person assigned to each county. The "county agent" is responsible for conducting field work in his or her respective county. In conducting field work, the first objective is to document services that are available. This is done by contacting the local health department, individual nurses within that organization, the churches, and local organizations such as Rotary, Kiwanis, Elks.

An important aspect of the inventory is that the potential service capacity of the community is determined. This objective is achieved by asking groups if they would consider offering services to the handicapped. With this information in hand, they can later tap these organizations for support. Before conducting the surveys, some training is given to the continuum of care team members. With some knowledge of the area, it reportedly takes about three weeks to compile the inventory. Four of the six inventories have been completed to date.

While this might be an excellent model for other agencies to consider, other State agencies report that little staff time is available to survey community resources. Therefore, resource inventories continue to be amassed through the "grapevine" and on an ad hoc basis.

D. COMMUNITY EDUCATION

Most program officials reported the need for community education services to advise people on the deinstitutionalization concept and develop interest in participating in community-based programs. In addition, services are badly needed to advise on the nature of specific illnesses such as mental illness, mental retardation and other disabilities that are conceived in the public eye to be either "unhealthy" or conditions which produce violent behavior. This issue will be discussed more fully in subsequent sections.

There was also a suggestion that services need to be provided to local County and State legislators to advise them of community programs, the impact on their districts, and provide them with information to support favorable decisions. Hard core data and research has to be made available to indicate the benefits of the deinstitutionalization approach.

VII.

Community Issues

There is widespread agreement on the importance of community issues to the implementation of deinstitutionalization policies and programs. The most significant issue is community resistance to these efforts, particularly to the location of community residences. In most cases, the forum for community resistance is the zoning hearing. Although this issue will be discussed later in detail, suffice it to say that in most cases, the use of a property for a community residence requires permission from the local zoning board of appeals or adjustment, or in some cases, the local legislative body.

Another significant community problem is the incompatibility of the community residence use with local and State codes and ordinances. Because this land use is relatively new, pertinent categories have not been established in the codes and ordinances; hence, difficulties ensue when trying to accommodate existing regulations to the new use. This issue will also be discussed in greater detail in subsequent sections.

A. COMMUNITY RESISTANCE

In an attempt to gain a greater understanding of community resistance to community residences, interviews were scheduled with community leaders in three representative Maryland communities; one in Baltimore City, one in the City of Frederick, which also involved the surrounding rural county, and one in a suburban area of northern Anne Arundel County. In addition, several sponsors of community residences were interviewed for their perceptions of community

issues. Interestingly, the feelings and attitudes of these people, although living in very different parts of the State, are remarkably similar. The following discussion reflects their fears and concerns about deinstitutionalization and community residecnes.

Acceptance of a Concept/Resistance to a Site: By and large, most people accept the importance and advantages of the deinstitutionalization concept. There is agreement that institutions have not performed as society had hoped and that some individuals can be better treated by diversion or release from these facilities to a community based facility. In addition, as families, they can appreciate the advantage of care which is located in close proximity to the home residence of the client or patient.

However, acceptance of a concept is a far cry from accepting a community residence in one's own neighborhood. When the dialogue begins to become more specific as to site, most residents will approve of the facility as long as it is placed in another neighborhood. Several other mechanisms take over once a neighborhood is chosen for the location of a community residence. The first response may be denial that the problem exists in the community for which the community residence is being established. This response has been very characteristic of some Western Maryland and Eastern Shore communities when approached about the establishment of a drug treatment program. In Anne Arundel County, those who opposed the community corrections center felt that crime was not a problem in their area, rather, it was perceived to be a problem in Baltimore City. These positions are maintained even if supporting evidence to the contrary is presented. For example, Anne Arundel County residents were told that a

a large number of offenders in the State penal system come from Anne Arundel County and return to the county after incarceration. In response to this information, residents suggested that these offenders originated from other parts of the county and that, therefore, their area was not the best suited for the center.

Another response of the community, once a specific site is selected, is to question the suitability of the chosen building or the neighborhood for the program. For example, one group opposed the location of a juvenile group home, citing the inadequacy of the backyard to accommodate the recreation demands of a group of eight teenage boys. Furthermore, the neighbors, who are mostly retired and past middle age, did not feel they could provide a compatible community environment for the youngsters. These objections seem to mask a more fundamental objection to the use of property in the neighborhood for a group home for adolescents.

Fear of Crime: Many residents have expressed fear that crime and violence will develop with the presence of group homes and other community residences. In particular, they fear auto theft, robbery, rape and threats to personal safety. If they report no personal fear of the situation, they often project and predict that their children will be afraid or be harmed.

The fear of crime is a very tenacious one, even when objective data proving otherwise is presented. In one instance, the potential sponsors of a drug program were assisted during zoning hearings by the expert testimony of the police from a community in which one of their programs was already located. The police advised the zoning board and observers that the existence of the drug free program had

acted as a deterrent in the area in which it was located. Although the police had no explanation for the phenomenon, they suspected that the existence of the drug free facility helped create an anti-crime image for the neighborhood and an impression that police protection had increased. Apparently, this testimony did not assuage fears because the request to locate the facility was rejected.

Where the criminal nature of the client is not in question, the fears of violence and personal safety continue to pervail. Residents believe that the mentally retarded and the mentally ill are subject to fits of violence and are a threat to the safety of the community. An instinctive response to the unknown develops a fear that the client population is harmful and a threat to personal safety. This response seems to develop even in the wake of evidence and information on the nature of the diseases and behavior patterns of clients.

There appears to be particular fear of the mentally ill. Program officials have explained this resistance is based on the perception of mental illness as a mysterious disease. Because of a lack of understanding, there is an assumption that mental illness is synonomous with being a sniper or a psychopath; consequently, a vague, diffuse fear of being attacked or physically harmed develops. This fear is accentuated by the misunderstanding that mentally ill persons have very unpredictable behavior. In reality, with the use of chemotherapy, behavior of the mentally ill becomes quite controlled and predictable. Unfortunately, the mental health associations have not been as active or persuasive as the ARC's in educating the public as to the real nature of the disease.

Misunderstanding and fear also prevail with regard to alcoholism. There is great resistance to the alcoholic because of the belief that the unattended drunk may kill, rape, or molest in a rage. Once again, this belief is far from the truth since most alcoholics are passive and near sleep when intoxicated.

Among other substance abusers, communities seem most resistant to methadone maintenance programs. The resistance seems to stem from fear of crime and of the possibility that the participants in these programs will "push" drugs in the community.

It is interesting to note, that once a center is established in a community, and the unknown becomes known, the fear level seems to diminish. Many program sponsors have related dramatic changes in community feelings from the planning to the operational stages. In one group home for girls in Anne Arundel County, after the facility had been in existence, many residents began to contribute food and clothing to the group home and to employ the residents as baby-sitters and yard workers.

Neighborhood Conditions: Many communities express opposition to the location of community residences because of the threat to the condition and character of the neighborhood. In Charles Village, Baltimore City, for example, the residents, after a long period of acceptance of community residences, have begun to object to the effects of community residences on noise levels, traffic and parking. In particular, they have come to oppose outpatient programs. These programs create significant traffic and parking problems because of the flow of people in and out of the facility. In addition, their experience has been that many outpatients come from outside

the community, are unemployed and therefore have a tendency to loiter outside the facility. They feel these conditions do not enhance the neighborhood environment.

Another concern is that the existence of community residences will cause a change in the character of the neighborhood, the deterioration of properties and, therefore, a reduction in property values. Once again, evidence to the contrary has been presented to communities. The drug program sponsors mentioned earlier found that in addition to having a positive impact on crime, the property values in the neighborhood surrounding their facility increased. Apparently, the proper maintenance of the facility encouraged other residents in the neighborhood to improve their own properties. In other cases, State program officials have reported that State-sponsored community residences are often maintained in better condition than other buildings in the neighborhood. Some program sponsors have expressed the need for more research on the subject of property values, which can then be presented to communities when making a request for zoning approval.

A more subtle concern about the change in the neighborhood character is related to the anticipation of odd behavior of the clients or patients. The expectation of unusual behavior by an intoxicated alcoholic, a recently-treated methodone patient, an elderly person approaching senility, or an excessively withdrawn person with mental illness often causes uneasiness among potential neighbors. In addition, an individual with a physical handicap or mentally retarding condition may not be cosmetically appealing to the general public. As stated earlier in this report, the movement

toward institutionalization was caused in large part because society had difficulties accepting these differences. Therefore, it is not surprising that community residents would have difficulty accepting these individuals on a daily basis as neighbors.

Community Integrity: In many ways, deinstitutionalization has again focused attention on the strengths of community life. This movement comes at a time when many communities are beginning to become more articulate about their needs and preferences, more resistant to decisions imposed upon them by a higher authority, and more disillusioned with governmental institutions. The acceptance of a community residence is one issue over which they have control. Unlike other government institutions with which they are familiar, the local zoning appeals or adjustment board is very responsive to the wishes of the community and many communities have chosen to use this institution as a vehicle for exerting authority over the climate and environment of their own neighborhood.

In other communities, other vehicles are being developed to oppose community residences. In Prince George's County, a bill has been introduced before the County Council which requires that community residences be licensed by the county government. The licensing provisions are directed more to protecting the county from the community residence than protecting the health and welfare of the individual living in the community residence. Local licensing would create a dual licensing procedure for those facilities that are already licensed by the State. If proposals such as these are permitted to pass, the future of community residences would clearly be in doubt.

Opposition to community residences often is the culmination of a long-standing feeling of resentment on the part of the community that it has been treated unfairly by the government. The reaction of the northern Anne Arundel County community to the proposed community corrections center site provides an example of this kind of response. The residents of that area considered the community corrections center as another unpleasant use being foisted on the community. The residents felt that their community had already been inundated with too many unpleasant uses, such as the county land fill, the transit bus depot, a general wrecking company, a fertilizer distribution center and heavy commercial activity on Ritchie Highway, while other communities in the county had been protected. This feeling of inequity is complicated by the fact that the northern Anne Arundel community is occupied by Blacks who have been residents of the area for decades. These residents perceive that over the years local officials have felt safe concentrating these noxious uses in the area.

A similar situation existed in Charles Village. For years, the area has been used by State and city officials as a location for community programs and as a result, over 35 social services programs are now in the area. The area was attractive because of its accessibility by public transportation and because the large homes in the neighborhood can accommodate a community treatment facility. In addition, other characteristics of the neighborhood, its transience and its heterogenity worked against any kind of community organization and resistance to community residences.

Recently, however, the homeowners in the Village have organized the Charles Village Civic Association with the purpose of protecting the integrity of their neighborhood. With regard to the concentration of community residences, the position of the community organization is that with the existence of 35 such facilities, they have more than met their share. They feel the community has been saturated and may be damaged by additional facilities; and there may be considerable justification for this position. They are now bringing pressure on local officials to disapprove zoning requests for additional community residences in Charles Village. They have developed their own approval process which includes an extensive interview with potential program sponsors to determine the effects of the intended program on their community. They have also resisted attempts to create programs which will provide services for the residents of other communities. As a result of the overconcentration of community residences, what was once a hospitable neighborhood is no longer.

Charles Village is an example of a community that is beginning to become conscious of its own needs and the impact of community residences and programs on their own neighborhood. Many other communities are beginning to ask the same questions about the benefits to the community of such a program. In addition, communities are also demanding to be informed about the programs and to be permitted full scale involvement in the decision-making process. These demands are often difficult to satisfy.

Program Credibility: Each of the community groups surveyed had serious questions about the credibility of the deinstitutionali-

zation and community residence programs. Some were suspicious over the projected staffing levels of the program. In Anne Arundel County, residents were told that low client/staff ratio at the community corrections center would help insure rehabilitation to the offender and safety to the surrounding community. Members of the community are very familiar with the staffing problem at Jessup and the inability of prison staff to secure funds for more guards and correctional officers. They simply did not believe that the necessary amount of funds would be forthcoming to staff the centers in the way that had been envisioned. Not to be dismissed is the influence of government statements made that community corrections would not be forced upon any community. As a result of this position, residents in northern Anne Arundel County felt they had good reason to question the commitment of State government to the program and were encouraged to resist the effort.

In Frederick, the community group opposing the siting of the group home was also concerned about the staffing of the facility. With an anticipated salary of $12,000 for a houseparent couple, they were concerned about the quality of persons who would take this position. Sponsors of this facility explained that because of additional benefits, the salary would actually be higher than the budgeted amount; the houseparents would become county employees and receive the fringe benefits of that system along with in-kind payments of room and board. Apparently, this information did not change the view of the community group.

In Charles Village, the community representative voiced concern over the short term nature of these community residences. He explained that the programs are normally in existence for two or three years, during which time the property begins to deteriorate. After this period, funds dry up and the program closes. Thereafter, the property is picked up by another group, the community residence cycle begins again and the property continues to deteriorate. This cyclical pattern causes the community considerable apprehension. The apprehension is aggravated by the fact that many program sponsors do not project a professional image and appear to have a casual attitude toward the impact of the project on the community.

In some communities, a poor experience has led the community to look askance at claims that the community based approach can be successful. In Charles Village, the community's experience with a methadone maintenance program was the precipitating event that caused the community to take a hard stand on requests to locate community residences in the area. Apparently, because of the lack of jobs, clients of this program loitered in the community after receiving treatment or sat in local eateries "nodding off" at tables. This behavior apparently offended many community members. In addition, a lively drug trade, where some of the clients sold their methadone supply, prospered outside of the facility. Lastly, the property was poorly maintained. In a Montgomery County community, the community had an unfavorable experience with a drug treatment program and thereafter refused to approve any others.

In both instances, it appears that more and better trained staff could have handled the difficulties. Unfortunately, as stated earlier in this paper, the salaries offered for community residence work do not attract the most highly trained personnel.

Lastly, there appears to be considerable ambivalence over the clients themselves, particularly juveniles, adult offenders and substance abusers. There seems to be a desire to believe that these people can be rehabilitated but, on the other hand, a pessimistic feeling that they cannot be. In addition, there is some resentment that these persons, in some cases will be receiving more benefits, i.e., health care, employment, education, than another person who might be upright and law abiding. A feeling prevails that these people should be punished for their behavior and should not be the recipients of preferential treatment.

B. EFFORTS TO NEUTRALIZE COMMUNITY RESISTANCE

Much effort has been spent trying to neutralize community resistance. The obvious solution of locating a community residence where opposition will not arise is increasingly unworkable because so many communities, even in neighborhoods once considered hospitable, are aware of the trend and are or have become organized to resist. Overcoming negative community reactions is especially important when it is realized that the optimal situation is community acceptance and participation in the activities of the facility.

Lack of Preparation: It should be noted that many State program officials and private sponsors did not anticipate the depth or intensity of community resistance to residential facilities. As

a result, many were unprepared to deal with the problems when programs were first initiated.

On the local level, a county executive seriously underestimated community opposition to drug treatment centers. He felt that the community would be more receptive to the idea if he pledged the strong support and leadership of the county government to the program. However, a community meeting called to discuss a specific site and zoning approval broke up in dissension even after these official assurances of support were given. Much of the opposition of the group was caused by poor management of some drug programs in the area and resulting behavior problems with the residents. In order to get a program in operation, the county had to buy land for the facility, rather than to rely on a neighborhood site and community approval.

As another example, the community resistance to the community corrections program has stalled the program for more than three years. The recent defeat of a site in Anne Arundel County was a significant setback for the program. Most of the problem has been created by the section of the law which requires local government approval of a community corrections center site. At the time the provision was included in the law, the Department of Public Safety and Correctional Services did not oppose it; they felt the requirement would not create problems since they had no intentions of locating a facility in a community without its approval. It has been reported that the Department never anticipated the violent reaction they later encountered in trying to locate these centers. If they had had any idea of the intensity of this resistance, it is

reported that their position might likely have been different when the opportunity to influence the inclusion of the local government approval requirement was available.

Despite this initial naiveté, most people involved in community residence programs are now well aware of the pitfalls that lie ahead for them in the community. Many approaches are now being tried to neutralize some of the opposition that inevitably develops.

County Placement: In some cases, community opposition has been neutralized by assuring residents that only persons from their own county will be placed in the community residences to be located in their neighborhood. Taking the initiative with this policy helps alleviate the fear that the neighborhood will be the "dumping ground" for persons in need from other counties.

Reliance on the Private Groups: One agency, the MRA, has relied heavily on the Association of Retarded Citizens to counter community fears and resistance. The ARC practices a very grass roots approach and holds meetings in family homes to discuss retardation and the need for group homes. Recently, the ARC intensified its efforts by bringing children who were candidates for group home living to these meetings to discuss their feelings and hopes about the home. This approach was very successful in sensitizing the participants to the need and to the nature of the clients. However, controversy over the specific site has not yet been resolved; thus determination cannot yet be made about the long term success of the ARC efforts.

Other agencies that sponsor group homes such as SSA and JSA rely on local program sponsors to neutralize community resistance.

However, the experiences of these sponsors differ. Many do not have the backing of a well-respected group like the ARC. Some are unsuccessful because they do not reflect a solid, stable image, like that exhibited by established churches and charities. In a study on juvenile group homes in Massachusetts, it was found that the name of the facility could cause considerable community resistance. For example, names or acronyms with an aggressive image like BURN! would arouse community fears unlike a facility sponsored by Catholic Charities whose title obscured the objectives of the facility.

Community Education: The Community Corrections Task Force has attempted to neutralize resistance by developing a comprehensive community awareness and education program. The staff learned the importance of the approach by trial and error. During the first years of the programs, implementation efforts were bogged down. Some officials believe that the difficulties arose because presentation of the idea to communities was never coordinated. Three institutions were involved in educating the community: Parole and Probation, JSA, and the Community Corrections Task Force (CCTF); and each was selling community corrections as a different concept. To parole and probation officials, community corrections meant prerelease; to JSA, it was an alternative to institutionalization for offenders; and to the CCTF, it was a combination of concepts. Consequently, considerable misinformation and confusion was experienced by the community, by the judges and other persons in the corrections profession.

Within the last year, a more systematic approach has been taken regarding community corrections. Staff from the CCTF have emerged as the spokespersons for the concept. In addition, an orderly process has been developed for making the community aware of community corrections. The process is based on three major elements: attitude research, identification of supporters, and issue responses.

First, attitude research and "rap sessions" were conducted in selected communities to discuss attitudes and responses to community corrections and crime. These data gave the staff a base from which to design their information strategy. Second, a procedure was developed for identifying support sources in a given target area. These sources would include citizen groups, key government officials, potential key supporters, potential technical experts, and communications/media personnel. The third step was to anticipate issues and develop responses with an emphasis on opportunities for the community in the community corrections process.

Thereafter, when approaching a county to find a location for a center, the following procedure is used:

1. public awareness build-up;
2. initial notification of support sources;
3. public hearings;
4. identify and recruit members for site selection committee;
5. citizen site selection committee meets and selects site;
6. development and mobilization of manpower to organize campaign support;
7. public hearings on site;
8. follow-up on decision-makers;
9. decision to approve or disapprove site made by local government;
10. if approved, site is purchased.

As can be seen, much emphasis is placed on citizen selection of the site. In fact, the CCTF established a policy that it would not approach a county or community with any preconceived notion of an appropriate site.

The CCTF has also developed brochures about the program that are distributed to residents of target areas and has plans for a sophisticated media program to increase awareness which will include TV spots, radio announcements and use of printed and outdoor advertising. (Federal funds for the CCTF expired at the end of June 1975; as a result, some of these plans may be cut short).

Despite these efforts at community education, the attempt to locate community corrections centers in each of the Maryland counties has continued to encounter serious difficulties. As a result, program officials have been forced to modify their objectives. As stated earlier, facilities are being located on State-owned property or as part of a jail facility. Efforts are being concentrated on developing sites for Baltimore City, and suitable sites are being developed to serve multi-county areas. All new efforts seem to be aimed at minimizing the risks of another defeat at the hands of the community.

Other agencies have developed education programs to deal with community opposition. Within the Division of Alcohol Control (MHA), the Maryland Institute of Alcoholism Studies was created to prepare information for non-professionals on the nature of alcoholism. Community education efforts have been aimed at informing interested and influential community persons about the disease, community programs and getting them to be the advocates

in the community. Often the DAC staff will identify interested people and invite them to seminars. This also proves to be a good way of finding potential sponsors of community programs.

Community Participation: Some agencies and program sponsors have found that community participation in assessing needs and guiding program operations can neutralize community resistance. DAA has encouraged the use of a community planning process to determine the need for drug abuse programs. This process occurs before the community has to deal with the acceptance of a particular facility. Therefore, it becomes more difficult to deny that the problem exists and to fight the location of a community residence if the community has already identified the existence of the problem and determined the need for assistance. The process was designed by the Drug Enforcement Administration of the U.S. Treasury Department and the National Association of State Drug Abuse Program Coordinators and compiled into a community education package. DAA used the approach in five counties with the hope of making them aware of their problems and preparing the way for a later request for permission to establish drug programs. Since that time, they have had acceptance of one residential facility in one of the counties and expect to receive approval from another. DAA officials feel that this less resistant community response is largely the result of the community planning process.

Community participation in the operation of the home helps to insure continuing community cooperation. Such participation is also a goal of community based programs with the intended purpose of aiding the clients' integrity into society. For example,

the Board of Directors of Harford Center, a residential program for mental retardates, is composed of influential county residents who support the efforts to the center before the county council and the community, and also help raise funds. Community boards are also being established for each community corrections center; the boards are given the authority to hire program directors.

Supportive Role of the Community Residence: There has been some conjecture that community resistance can be neutralized if the community residence can provide the larger community with services that it may need or desire. In this connection, the community corrections staff also has given some thought to the kind of supportive role the facility and its residents might play for the surrounding community. At one point, the staff was considering the possibility of offering the medical services available in the corrections center to the larger community. It was suggested that the medical clinic be open exclusively for the community for certain hours and days. In addition, the medical clinic was designed so that there would be separate entrances for the community and the center residents. Moreover, space was going to be made available for private physicians and dentists to locate practices at the facility. The staff also considered other opportunities such as opening up the recreation space in the centers to the community and sponsoring Boy Scout Troops. In the wake of the severe community resistance experience, the staff has not had the opportunity to promote the potential of this supportive role with the community. Some correction officials feel that resistance to community corrections is so fundamental that efforts to

overcome it by promoting the corrections center as a supportive service institution in the community will not be successful.

C. ACCEPTANCE IN THE COMMUNITY

As stated earlier, over 200 community residences exist in the State of Maryland. Many of these were established prior to the recent increase in public awareness and resistance. Currently, community resistance to the concept is widespread and it threatens future development of such facilities. However, despite these prevalent attitudes, certain areas of the State are less resistant to the concept than others. In addition, some clients or patients seem to engender less resistance than others. These issues will be discussed below.

Community/Geographic Differences: Many program officials have stated that is is not necessarily a desirable location, it is least difficult to obtain sites for community residences in rural areas. Several reasons may be given for this experience. First, rural areas are less densely settled than more urban areas and, hence, there is less impact on an existing population. Further, many rural communities may be less well organized and less sophisticated to respond to an issue such as the location of a community residence, than either the suburban or the city neighborhoods.

However, despite these characteristics, community residences are not concentrated in rural areas. Some of the characteristics of the rural population make this mode of treatment unnecessary. Perhaps because of the greater existence and viability of the extended family in rural areas, a relative is more likely to be available to provide care and supervision for an aberrant family

member. For example, an alcoholic in one of the rural communities would likely be cared for and detoxified at home. Therefore, when DAC officials make plans for the alcoholics who come from these communities, they do not insist on developing community residences since their clients already have stable living arrangements. Instead, they try to develop ways to help the family continue this care. For example, if the individual providing care is aging and cannot provide supervision for an alcoholic family member on a full time basis, program officials try to enroll the alcoholic in a day care program so that some of the burden is taken off the family. In this way, they hope to keep the alcoholic in his or her community, where he or she is accepted and cared for as an individual, instead of being forced into the larger urban areas when such a climate will not exist.

The same kind of protection might be provided for the mentally ill. In most small communities, a mentally ill person would be well known by the town residents, and would be under the care of his or her family. Long acquaintance with the individual and the knowledge that the family is taking responsibility for his care and behavior help other community members accept the individual.

Community facilities are not concentrated in rural areas for other reasons. Because of the sparse population, there is less need for the facilities than in more densely settled areas. To establish such facilities and fill the empty beds with individuals from other parts of the State would be obviating the goals of deinstitutionalization by providing care that is not within the

individual's own community. Second, location in a rural area creates an accessibility problem when it comes to linking up with other supportive services.

Unfortunatately, in more densely populated and accessible neighborhoods, such as the suburbs and urban working class communities, community resistance to community residences appears to be the strongest. This resistance may be part of the common reaction of residents of these areas to be wary of overtures both from the private and public sectors to introduce change into the communities. Montgomery County appears to be an exception to this generalization, but there is agreement among State officials that this County is atypical of other Maryland counties in terms of income, occupation and political philosophy.

Several different types of neighborhoods have been found in which a community residence may be acceptable. It has not, however, been determined that these are best locations in terms of treatment or impact on the neighborhood. The first type is a transition neighborhood. In these areas, old behavior and neighborhood patterns are changing and as a result, there is little likelihood of strong organized resistance. Another example would be a neighborhood that houses transient population. These areas have a high proportion of boarders and students, and offer the added benefit of houses that are large enough to accommodate the needs of a group. The third kind of neighborhood is a lower income neighborhood. In general, housing costs would be low and therefore manageable within the program budget. The community may exhibit less political cohesion and, therefore, less political influence. Residents of low income

areas may also have a greater tolerance for aberrant members of the larger community.

Some program sponsors have found that rundown commercial areas offer good opportunities for locating a community residence. Business interests in these areas are less resistant to the siting of a facility. In addition, it is doubtful that the larger community would resist the location of a community facility if it were a commercial district. However, this type of location is not as compatible with needed treatment environments. In addition, it is likely that any structure selected would be inadequate and require extensive renovation and high maintenance costs. This condition would also be prevalent no doubt in other rundown areas even if they were residential in character.

Response to Clients: There appears to be greater acceptance of persons with physical handicaps than those with mental handicaps. The physically handicapped individual has a disorder which is visible and one that is not associated with violent or deviant behavior. This individual is more trusted by the community although opposition may develop for cosmetic reasons. Nevertheless, it woul appear that locating community residences for these clients would be the most potentially successful.

There appears to be a greater acceptance in the community of the mentally retarded than the mentally ill. The Association for Retarded Citizens has been an active and potent force in educating the community on the nature of mental retardation. The group is composed largely of parents and families of retarded persons who are committed and well-respected in the community. However,

despite the work of ARC, there is still confusion in the mind of the community between mental retardation and mental illness. It is feared that mentally retarded persons are violent persons who will threaten their security. Perhaps because of these residual fears, zoning problems and defeats still occur when trying to site a community residence for the mentally retarded.

With regard to children, there seems to be greater acceptance of community residences for dependent or neglected children than for young people exhibiting forms of anti-social behavior. The fear of crime and threats to personal safety appear to predominate when the community has to approve a home for juvenile delinquents or other aggressive children.

It would also be anticipated that little resistance would be experienced in setting up a community residence for the elderly. This group does not arouse many of the fears associated with other portions of the institutionalized population.

Among drug abusers, there is a greater receptivity in the community to soft-drug users than heroin or other hard drug users. One explanation for this attitude may be that use of soft drugs has become widespread among young people and that crime is not associated with its use.

D. INCOMPATIBILITIES WITH CODES AND ORDINANCES

Many serious difficulties have been cited in complying with State and local codes and ordinances. In most cases, difficulties have arisen because few of these regulations have a classification dealing with community residences. As a result, in determining compliance, another similar use has to be used as the standard.

This is often confusing and inappropriate since a community residence has needs and requirements that are unique to its specific use and not covered by other uses. Another general problem seems to be that local officials review the compliance of community residences with local fire, health, zoning and building codes with greater rigor than they would an individual family home. It is alleged that strict enforcement of these local regulations becomes another manner in which the neighborhood can resist the community residence.

Fire Codes: There appears to be some agreement among group home sponsors that the State fire code, Life Safety Code 101, imposes unnecessarily severe restrictions on the sponsors of community residences. Fire officials, however, believe the requirements are appropriate. These requirements are usually translated into financial expenditures for improvements to insure greater fire protection. With the scarce resources that are available for these facilities, the costs are usually prohibitive for the program budget, and cause greater difficulty in getting community residences established.

The State Fire Marshall administers the fire code and generally inspects a facility at some point in the licensing procedure. Therefore, facilities that are licensed such as DHR child care facilities, MRA homes and DAC quarter way houses receive a fire inspection during licensing. Inspection is supposed to take place before occupancy but in some cases this does not occur. The Fire Marshall is opposed to early occupancy, but appears to have no policy or procedures to enforce this point of view.

Other facilities such as JSA group homes and DAC halfway houses are not licensed and, therefore, do not automatically get inspected for compliance with the fire code. JSA does require such inspections, however. Nevertheless, these unlicensed facilities are still subject to the State fire code. Inspection for compliance does not take place on a routine basis; instead, the Fire Marshall and his staff only inspect upon special request by an individual, the community or some other source. For example, Harford Haven, a JSA group home for boys in Bel Air, was inspected because Insurance Commissioner Thomas Haten, who served on the Board of the facility, requested an inspection and assurance that the building was safe.

The unlicensed facility has created embarassments for the State. In one instance, the Howard County Department of Licensing and Permits was called by local people to inspect a JSA purchase of care home in Laurel. The facility was judged to be in such poor shape that a court order was issued to remove the children. A difficult situation was created since one State agency, JSA, and the county officials were in disagreement.

Specific requirements to insure fire protection in community residences or group homes are not set out in the code. Instead, other classifications regulate these facilities. It is important to note that in the fire code, restrictions differ depending upon the number of people residing in the facility and the extent of their disability or restraint. For example, in a home for mental retardates, or in a domiciliary care facility where there is some or total incapacity on the part of the client, it is likely that fire protection standards will be higher.

Difficulties with the fire code usually occur for a facility housing three to fifteen unrelated persons. For any number under three, the facility is considered a single family residence and, therefore, not subject to more restrictive fire protection standards. When housing between 3-15, the residence takes on the classification of a boarding home and becomes subject to the regulations for that use. For this more intense use, certain extra precautions have to be taken to insure protection. Most private residences converted to this use do not meet code standards; they have inadequate exits and fire alarm systems, highly combustible interior finishes and unenclosed stairways.

Sponsors of community homes generally find that these requirements are inappropriate. They view their fire protection needs as similar to those of another family. The Fire Marshall's Office does not agree and believes the code cannot be interpreted in this manner. The Office supports the more standard definition of family in which those who are not related are not a family. In further support of his position, the Office maintains that the home serves wards of the State and, therefore, the State has to assure that the minimum level of protection required is actually provided.

When dealing with a facility that houses more than 15 unrelated persons, the hotel/dormitory classification applies. To insure the protection of this greater number of people, the basic construction of the building becomes of concern. If the frame is of a highly combustible material, a requirement might be issued to include provision for a sprinkler system and smoke detection system. One drug treatment facility which houses more than 30

residents was recently required to install a sprinkler system at a cost of $15,000.

In general, most problems occur in trying to qualify an existing building for group living. The Fire Marshall believes that whenever a conversion of the original use is contemplated, problems occur since the original design and construction were not developed with the more intensive use in mind. In the construction of new buildings, the physical plans are usually designed to accommodate the fire protection requirements.

Building Codes: Building codes are in existence in all but 10 counties in the State; these jurisdictions being concentrated in Western Maryland and the Eastern Shore. The codes address the structure of the building to protect it from damage by wind, storm, collapse, fire and other hazards. The code provides the structural requirements that a building must satisfy to be in compliance with the State fire code.

Like the fire code, the main problem with the building codes is that group homes are not identified or defined. As a result, other definitions are used to regulate these facilities. There seems to be a difference of opinion as to how the code affects community residences. Program personnel have asserted that the residential classifications be used to cover group homes of 15 or less unrelated individuals. This kind of designation would likely require only minor investment in fire protection improvements and would be compatible with the family atmosphere which characterizes many community residence programs.

The Fire Marshall's Office opposes this interpretation and feels it contradicts the code requirements. He feels that once the facility begins to house more than three unrelated persons, it begins to come under consideration as an institutional use. With the institutional designation, more stringent structural requirements are placed on the facility to make it more fire resistant. As a result, more money may be needed to construct the facility in compliance with the code.

Since a review was not made of the enforcement of local building codes, it could not be determined whether this conflict exists on the county level and/or how it is resolved. However, it appears that any problems with the code would be experienced with new rather than existing structures. The major reason for this difference is that most building codes have been approved in the last few years and pre-existing buildings do not have to meet code requirements.

Health Codes: Both State and local health codes exist which require that certain standards regarding drainage, weed control, insect and rodent control, sanitary conditions, communicable diseases and the accumulation of trash be maintained. In most jurisdictions, the State public health code prevails except in those counties where local codes are equal to or exceed State code requirements.

Several years ago, many group home sponsors were having difficulty meeting the food preparation requirements of the health codes. Because of the number of people residing in a group home, there was a tendency to apply the restaurant classification to the facility and request that a separate room and special equipment be provided

for food preparation. Group home sponsors objected to these requirements because of the costs involved and because the family atmosphere of the group home was to be aided by the communal preparation and taking of meals. Ultimately, a State law was passed which exempted group homes of less than 14, including staff, from the food service requirements of the codes.

As with other codes, a specific set of criteria are not set forth for community residences or group homes. Since they are a hybrid between a residence and an institution, some program officials report that confusion exists over what inspection procedures apply to these facilities. Juvenile Services standards require annual reviews of facilities by health officials. In other cases, facilities are not routinely inspected because of excessive demands on the local health department inspection staff.

In any event, some officials are reporting that they do not receive sufficient guidance from the local health department on sanitation control, food preparation, and so on. This perceived lack of direction may be caused by uncertainty on the part of the health department staff as to which requirements are applicable.

Zoning Ordinances: There is widespread agreement that the zoning difficulties present one of the greatest problems in the implementation of deinstitutionalization. Vast amounts of staff time, energies and program resources are spent in efforts to obtain favorable zoning decisions, often without success. As an illustration, the Second Genesis, which is a well-respected

drug treatment program, has one center in operation in Montgomery County and another in Prince George's County. They were unsuccessful in getting zoning approval to establish additional facilities in these two counties and were finally aided by local government purchase of the necessary sites.

They have also approached communities in Charles, St. Mary's and Frederick Counties and in Baltimore City, and have failed in each case to be approved through the normal zoning process. In another case, one potential sponsor of a juvenile group home, Frederick County Group Homes, Inc., worked for two years to secure a site for a juvenile group home to be supported with State and U.S. Law Enforcement Assistance Administration funds. The sponsor has proposed three different sites, has lost $10,000 in appraisal fees, and has had to pay for attorneys' fees for zoning and court hearings on two potential sites. Currently, the only way they expect to establish a program is for the State to acquire the site and lease it to their corporation.

Much diversity exists in the treatment of group homes or community residences in zoning ordinances across the State. This diversity is due largely to the fact that the power to zone has been delegated to local jurisdictions. Each zoning ordinance reflects the unique character of the community and its zoning policies. This diversity creates many different kinds of problems for sponsors of community residences. In addition, community opposition usually crystallizes around the request of the facility sponsor for approval by the zoning administrator or zoning appeals board.

Generally, problems arise because the zoning ordinance is silent on the issue of community residences or group homes. The concept of community-based treatment and the use of community residences or group homes is a relatively recent phenomenon. Most local planners have not anticipated the trend and, as a result, the zoning ordinances have not been updated to reflect these new uses. Consequently, the emotional conflict which arises over a community residence is additionally burdened by an unprepared regulatory structure. Often, courts are called upon to resolve the conflicting issues.*

Where a zoning ordinance is silent on group homes, sponsors choose one of several strategies, all of which result in difficulties.

Definition of "Family": One strategy is to locate in a single family residential unit as a "family" and to avoid the zoning ordinance altogether. Most zoning ordinances do not permit group homes in single family districts, because they do not fit the mold or lifestyle of the nuclear family. However, most ordinances also define a family as a group of unrelated individuals numbering anywhere from 2-6, who live together and operate as a "single house keeping unit". Generally, this term has been interpreted to mean that meals are taken together, that financial responsibilities become the responsibility of one of the group's members and that other such behavior attributable to family living

*From "Zoning for Family & Group Care Facilities", by Daniel Lauber and Frank S. Bangs, Jr. ASPO Planning Advisory Service, Report #300, March 1974.

is exhibited. By using this definition and by housing the permitted number of individuals, a program could be located in a residential area.

However, it is often difficult to meet this condition. For example, mental health halfway houses were set up in residential neighborhoods in Montgomery County under a family definition which permits five unrelated persons to live in a single family residential district. Program sponsors provided residential placements for five ex-patients. One staff person was placed to work with these patients. In an attempt to justify the sixth person, program sponsors claimed that the staff person served in a servant capacity. The zoning law provided that servants would not be enumerated as part of the family group. The neighbors did not accept this explanation and reported them to the zoning board whereupon they were found in violation of the zoning ordinance and were requested to vacate the premises. This approach was attempted several times and each time the sponsors had to move. Significant levels of energy were spent opening and moving programs.

They persevered with this six-person approach because they found that the costs of operating the facility required a bare minimum of five patients. In most instances, five persons was not a sufficient number to support of the progran financially. Each individual's share of the monthly rent was high, particularly because of the high cost of housing in Montgomery County, In addition, sufficient funds were not available for maintenance. The per diem rate was $15.50 or over $400 a month. These costs were far greater than many ex-patients could afford. Moreover,

since the program budget was so dependent upon each patient's share, financial difficulties increased during periods in which there was less than 100% occupancy.

Use of Similar Classifications: Some zoning ordinances permit uses such as community care institutions, health clinics, boarding houses, rooming houses, lodging homes, or dormitories by right in certain areas within the jurisdiction. Procedurally, no zoning approval is necessary as long as the use is specifically identified as a permissable use in the ordinance. In other areas of the jurisdiction, these uses may be permitted conditionally if certain safeguards set forth in the ordinance are met. Normally, an administrative determination that the conditions have been satisfied is made by the zoning administrator. No further approval is generally required.

Some group home or community residence sponsors will try to avoid conflict by defining their facilities as one of these similar uses. Using a similar definition has some advantages since the use is more acceptable to the community, it is provided for and regulated by the ordinance, and it is a use with physical needs for space and, perhaps, parking similar to a community residence or group.

However, the approach has some long term limitations. While a community residence may be physically similar to other uses, its function, social needs and effects are quite different, from, for example, a rooming house. In a community residence, a close family atmosphere is a necessary part of the program. The areas

in which these similar uses are permitted may not have such an atmosphere.

In addition, the approach is not foolproof for short term objectives. An informed or aroused public can easily appeal the approval of a conditional use, made by the zoning staff, to the zoning appeals board. Moreover, most group home sponsors prefer to be located in a low density residential neighborhood where they can be absorbed into the community like any other family, and where the environment is beneficial to the needs of the patients. The uses mentioned above are often relegated to areas within the jurisdiction that may not be compatible, such as a commercial mixed use, or apartment district, or areas that have deteriorated.

Use of the Special Exception: In many cases, group home sponsors have to request a special exception to be able to set up a facility in a given community. The special exception procedures are usually more lengthy and demanding than those for conditional use approval; the decision to approve a special exception normally has to be made by the zoning appeals board after public notice and public hearings have been held. The board is very responsive to the views of the community, and it provides an excellent forum for the expression of community resistance.

To guide the board in its decision-making, various conditions are set forth in the ordinance which must be met if the applicant is to receive approval. Generally, these conditions are written so broadly that compliance with the conditions is difficult to assure, particularly if the board is opposed to the use. For

example, in the Frederick City zoning ordinance, the board is advised to disapprove special exception permits if:

> "The proposed building, addition, extension of building or use, sign, use or change of use would adversely affect the public health, safety, security, morals, or general welfare, or would result in dangerous traffic conditions, or would jeopardize the lives or property of people living in the neighborhood..."

In addition to this general admonition, the board is also directed to give consideration to the following conditions, among others:

> "...c. The orderly growth and improvement of the neighborhood and community...
> g. The effect of such use upon the peaceful enjoyment of people in their homes...
> i. The conservation of property values...
> n. The contribution, if any, such proposed use, building or addition would make toward the deterioration of areas and neighborhoods..."

As stated earlier, these are issues around which the community rallies. Faced with such opposition, it is difficult for group home sponsors to convince the appeals board that it will not have such adverse effects on the neighborhood. For example, presentation of expert testimony from police or other group home sponsors on the positive impact of a group home on crime reduction, maintenance of the community and property values have proved fruitless.

Use of the Variance: In Baltimore City, a conditional use procedure has been instituted where zoning approval of a variety of community facilities including nursing homes, alcohol rehabilitation centers, drug treatment programs and community corrections centers has to be determined by the legislative body. A proposal to approve such a facility has to be submitted to the City Council, sponsored by the member of the council who represents the impacted

community, public hearings are held, and the council votes on the proposal as it would on any legislative item. Thus, approval constitutes passage of a city ordinance.

Prohibition of Group Homes: In some cases, a local zoning ordinance recognizes community residences, but prohibits their use from being established within the jurisdiction. In Baltimore County, such a prohibition has existed. The only way in which such facilities could be located in that county was for the State to acquire the land and construct the facility.

Recently, this provision has been amended largely because of the efforts of the Association for Retarded Citizens. Group homes for the mentally retarded are now permitted in the county although those for persons with criminal behavior are still prohibited. Apparently, some uncertainty exists over the definition of "criminal behavior." There is consensus that group homes for youngsters who are identified by the court as Children in Need of Supervision (CINS). These children normally have committed no crime, but they are considered to be pre-delinquent because they exhibit incorrigible, unruly behavior or other behavior patterns which make them unmanageable in their home situations.

In a few rare cases, local elected officials and planning staff have anticipated the advent of community residences and have provided for them in the zoning ordinance. However, they still become the subject of a zoning controversy. The experiences of the Frederick County Group Homes, Inc. organization in trying to locate a juvenile group home in Frederick City provides an excellent case study of the difficulties that ensue.

In early 1973, a church group came to the Planning Department and advised the staff that they wanted to establish a group home for disadvantaged boys in the city. At the direction of the City Council, the planning staff drafted an amendment to the zoning ordinance which was passed by the Council. The amendment provided that group homes be allowed, as a conditional use, in multi-family, or R-4 districts. By inference, the use was permitted by right in areas such as business and commercial districts. It was decided that for the good of the clients, these homes should be prohibited from industrial areas. It should be noted that during the drafting of this amendment, there was little information available to assist in the decision-making. No other local government in Maryland had developed a permissable, comprehensive ordinance for group homes that could be reviewed or used as a model.

Once the ordinance was passed, the church selected a site in a low density residential district which was approved by the zoning board without any opposition. Planning staff suggested that the lack of community opposition resulted from the fact that the group had considerable credibility and support in the community, because group members had been very active in securing support for the facility, and because the issue of group homes was not one which many of the neighbors were familiar.

The next attempt to locate a group home in the city was opposed consistently by the community. Frederick County Group Homes, Inc., has tried to get approval for three sites in Frederick County, two of which were in the city. The first site, located on North Market Street caused considerable problems for

the group. By that time, enough publicity had been given to group homes that residents were primed for the zoning issue. Instead of fighting the first site on a zoning issue, the neighbors alleged that the home did not conform to the restrictive convenants placed on the land. These covenants, written in 1932, required that 14 conditions be met; conditions which were outdated and with which no other neighbors were in conformance. Although the corporation felt they could fight the issue in court, they decided to look for another site rather than be held up in a court suit. At that time, the board recommended that the facility be located in a B-2 area, since the group home was technically a business. Thereafter, and in keeping with this suggestion, they selected a site on North Third Street in a B-2 district.

The Third Street community was more resistant than the Market Street neighborhood. The area was inhabitated by many long-established Frederick families who resented the intrusion into their community. In addition, many were preservationists, concerned with the historical character and condition of the buildings. On the other hand, proponents felt the site was an excellent location, with easy access to commercial areas, schools and recreation. In conformance with the zoning provisions, the group applied for and received a building permit from the City Engineer for the property.

The Third Street group appealed the decision of the City Engineer and alleged that he acted in error by approving the building permit. The basis of the case rested with the procedures that apply to conditional uses. Group homes were considered a "conditional use" in R-4 districts. Procedurally, this designation means

that the use is identified in the ordinance and that a request to use land and property for that purpose usually has to be reviewed and approved by the zoning appeals board. If the use was designated as a "permissable use", no hearing would be necessary. It is at the hearing stage that opposition to a particular use can be effective.

In order to avoid the difficulties attendant with "conditional use" in the R-4 district, the Frederick City zoning ordinance permitted group homes to be located in B-2 districts. Rather than listing all permitted uses individually, the ordinance allowed any use in the R-4 district to be allowed in the B-2 district "but without the same conditions." By reference, the intent of the ordinance was to permit all "conditional uses" in the R-4 district to be established in the B-2 district without the necessity of the hearing process.

The opposition rejected the attempt to include group homes in B-2 districts by reference. They felt that since group homes were not specifically listed in the B-2 regulations, they could not be interpreted as being permitted by right and that the Board of Appeals had the right to hear the group home request as a conditional use.

The local planner testified that the intent of the City Council in reviewing the group home issue was to allow the use in R-4 districts, providing it was approved by the appeals board but to permit it without those conditions in higher density residential and commercial areas such as B-2 districts. Furthermore, the group home sponsors testified that the courts had advised them to locate in a B-2 district. Nevertheless, the Board of Zoning

appeals supported the community and overturned the decision of the City Engineer.

This issue has been appealed by the group home organization to the courts. If the court overturns the decision of the zoning board, they can go ahead with plans. If the court supports the board, the group will have to go through what undoubtedly will be a grueling conditional use proceeding. To avoid this prospect, they are anticipating that the State will assist them by acquiring the property and leasing it to them. If they are not successful in opening a group home by the end of the year, the funds that have been earmarked for them by the State LEAA planning agency will be reallocated.*

*Since this report was written, the court has decided in favor of the group home which has now been purchased by the State for a leaseback arrangement.

VIII.
Recommendations and Potential Solutions

As a result of the research, certain overall findings have emerged regarding the process of deinstitutionalization. These are discussed in previous chapters. In response to these findings, suggested recommendations and strategies have been developed for State agencies, the Legislature and local governments to consider in their future plans for deinstitutionalization. The suggestions result from an analysis of the literature review, discussions with State program officials and from a random inventory of the activities of other States as they attempt to deal with the problems of deinstitutionalization.

A. CENTRALIZED COORDINATION OF STATE DEINSTITUTIONALIZATION ACTIVITIES

Currently, the major Departments of State government are involved in carrying out deinstitutionalization policies. No structure exists to coordinate these activities. As a result, each agency is developing its own programs despite the fact that many of these programs have significant effects upon and are affected by the activities of other Departments.

The lack of coordination between State agencies with regard to deinstitutionalization plans is detrimental to the deinstitutionalization effort. By its very nature, deinstitutionalization demands that a mix of services and programs, which are the responsibility of a wide variety of agencies, be coordinated and available to the client. It seems necessary, therefore, to adopt a mechanism that

would be responsible for integrating the efforts of various State agencies. Furthermore, coordination could result in cost savings for the agencies and could help prevent overloading any neighborhood with an excessive number of community residences.

There also needs to be coordination between institutional staff and the staff operating community programs. Too often a professional schism exists between these two groups. This gap can be particularly troublesome since the cooperation of both staffs is necessary to move the client or patient through the continuum of care or service system.

Coordination also has to be developed between private careholders such as sponsors of community residences and nursing homes and public or private service programs so that clients can benefit from supportive services in the community. Central agencies might develop guidelines to assist in this cooperative effort.

Several different kinds of coordination have to be encouraged in the State. Within each agency the activities of the central office and the local or regional offices have to be coordinated so that policy and program decisions reach the operation of the system. In addition, coordination is also needed between local offices of different agencies.

Therefore, a recommendation is offered to establish a three part policy-making and coordination process for deinstitutionalization. This would include a high level policy task force that could issue policy statements and monitor actions to assure their implementation. Other recommendations in this chapter identify priority matters for the attention of this group. The task force should include key representatives of the Governor's Office, State

agencies, the Legislature, and some local officials. The Governor's Office will be informed of the need for such a task force and asked to establish it.

The second part would be a program managers' task force to provide coordination at the operational level. This group would establish procedures for inter-agency and intra-agency integration. It would be the responsibility of this level to assure that no community is overloaded with group homes, that follow-up of related patients occurs, and that services available through a State Department are provided to the other agencies that require this component in their programs. Joint ventures could also be arranged through this group.

Finally, a local task force would be needed in each county. The local group would be composed of program operators and government officials. This group would work with the State level program managers' task force on specific proposals. This arrangement would allow for local input in planning for community facilities and avoid the confusion arising out of fragmented State approaches to individual communities.

Procedures would need to be developed for the manner in which the second and third groups would deal with each other. The recommendation provides the potential for localities to deal with one centralized group for all deinstitutionalization efforts rather than dealing with a variety of State agencies separately regarding each facility. It would be the responsibility of the local task forces to work with neighborhoods concerning specific proposals and assist in obtaining approval for specific sites.

In a study done by the University of Texas, it was pointed out that formalized relationships between the community mental health centers and the social service agencies were beneficial to the administration of programs. Local agencies can talk about unnecessary duplication, coordination of program activities, and exchange of highly skilled staff; they can also realistically assess their resources. Such information can then be transmitted back to the central agencies for input into State agency plans.

In New York State, despite other problems with the deinstitutionalization effort, one aspect of the program appears worthy of replication. Coordination at the local level is achieved by requiring formal approval of a community residence by sister agencies. For example, if a home for mental retardation is to be established, the facility must be approved by the county mental health board, the education officials and the regional representative of the State's mental retardation agency. At the very minimun, this approval process makes other agencies aware of the group homes and gives the opportunity to consider the demands the facility will place on the supportive services each agency supplies.

B. ENUNCIATION OF STATE POLICY

It seems that a clear enunciation of State policy is needed both to provide direction for State agencies and to inform the general public. This could be accomplished through the issuance of a joint Executive and Legislative Policy Statement. The statement would identify the position of key policy makers with regard to community-based treatment programs and the movement to reduce the institutionalized population. This effort would provide a framework for all activity in the State regarding deinstitutionalization. The policy level task force recommended above would be an

appropriate group to issue such a statement. The policy should be based on an assessment of past deinstitutionalization efforts and a determination of the direction and pace of future activities.

Part of this review should also include a realistic assessment of kinds of individuals who will need to remain institutionalized. It is clear that some people will never be capable of handling community life particularly those with chronic conditions or those, as mentioned above, who may be a threat to the community.

The results of this study indicate that assumptions made about deinstitutionalization might be reviewed with an aim toward developing a more selective deinstitutionalization policy. Currently, Maryland citizens are being asked to approve community residences for adult offenders, youths, mental retardates, persons with mental illness, substance abusers, the physically handicapped and the elderly. Community resistance is common, threatening the progress of these efforts. The very fact that communities must cope with all of these client groups may intensify their opposition. For example, in the State of Kentucky, a limited deinstitutionalization effort is underway for mental retardates and alcoholics. Reports indicate that with a considerable amount of community participation, community residences for these clients are being accepted.

In two studies done to evaluate community based mental health care in the State of Illinois, it was found that the costs of serving chronic patients in community care was greater than when they were hospitalized, with no accompanying higher success rate in reducing recidivism among these patients. The study also found

that community based care was less expensive and more successful with patients who were entering the system of care for the first time.

Based on studies of this nature and the opinion of many professionals, institutions will continue to be needed to serve certain people. However, activities carried on within the institution and by institutional staff could complement community based care. Hospitals could, for example, work more closely with communities and with the families of patients. They could provide day care, outreach, follow-up, sheltered living and working arrangements for many of the inpatients. In so doing, they can use their vast resources in a manner similar to a very large and well financed community health center.

Consideration should also be given to the impact of inadequate community resources on the released or diverted institutional client. Many times, unavailable and fragmented support services such as housing, health care, and social services cause service problems for these individuals and make it difficult for them to maintain themselves in communities. The agencies should be requested to look at the gaps which exist in the system and readjust their release schedules accordingly.

Policies must also be developed with regard to siting criteria for community facilities. The advantages and disadvantages of locating community residences in proximity to one another should be examined. Characteristics of a desirable host community for different types of facilities should be delineated. Individual sets of criteria may need to be developed for each type of community residence.

C. FUNDING FOR DEINSTITUTIONALIZATION ACTIVITIES

With regard to funding for community residences, several recommendations can be offered. There must be an understanding on the part of both the Executive and Legislative branches that the initial cost of establishing a community residence system may be considerable. Several factors must be considered in determining costs including number of clients, their characteristics, and ancillary service costs. Furthermore, the transitional period during which the existing institutions must be funded at current levels and the new community residences are experiencing start up costs must be considered. There must be a willingness to provide funds at appropriate levels for several years.

However, program advocates have to accept the bitter facts that adequate funds do not exist to provide all the programs that are needed for deinstitutionalized Maryland residents. Therefore, priorities have to be set and decisions have to be made as to how funds will be spent.

A broader study would be desirable to explore alternate budget practices for the funding of community residences. The grant approach to cover the cost of a year's operation may be more appropriate than a per client reimbursement system. In addition, the study should explore ways of stabilizing funding so that sponsors do not encounter difficulty when Federal support is reduced or they have some temporarily unfilled slots.

To insure that community reintegration is accomplished, the State might borrow from the Kansas experience and consider putting an item in each agency's budget specifically for efforts to re-absorb persons in the community. These funds would then be used to

finance living arrangments, purchase of supportive services, and other necessary expenditures. The funds in the reintegration budget will control the flow of persons into the community. As a result, the pace of deinstitutionalization will be slowed but, on the other hand, adequate financial and service plans will have been made for those persons who are to be released.

It might be appropriate for agencies to explore alternative means of financing community based efforts. In other states, most notably, Massachusetts, the Office of Elder Affairs and Brandeis University are investigating ways in which after care and community based services can be packaged and reimbursed through third party payment mechanisms: Medicare, Medicaid, Blue Cross/Blue Shield. The theory behind this approach is that without the community care, the patients would continue either as inpatients, or having been released without the existence of after care services, they would have to be readmitted to the hospital. Therefore, by accepting the costs for the community care package, the insurance organizations, both public and private would be accruing lower costs. In another State, Kentucky, the local community mental health centers have the authority to raise their own funds by adding millages to the property tax. In Maryland, Allegany County is raising funds for an alcohol treatment facility by using 20% of the beverage tax.

D. REEVALUATION OF PURCHASE OF CARE RATES

Closely related to the issue of inadequate funding for programs is the existing purchase of care rate. Many people feel that this rate does not reflect the true cost of community care. An inade-

quate purchase of care rate is apparently threatening many community residence programs.

The purchase of care rate question has a much broader scope than deinstitutionalization. The success of other agencies from which the State purchases social and rehabilitative services is also threatened. A recent study conducted for the Department of State Planning by the Health and Welfare Council of Maryland found that many agencies in the voluntary sector feel that the purchase of care rates are inadequate to meet the demands of increasing costs and the demands for quality programs and services. In addition to the controversy over the rate, many program officials feel that the system is based on a common denominator of care and does not provide enough flexibility to deal with the specialized needs of persons in need. An objective study is needed to determine the validity of these criticisms.

It is recommended that an interagency effort to examine the real costs of community care, identify the services that are needed and develop appropriate reimbursement rates be initiated. Special attention should be given to those costs which are not now being included in the rate such as the extra insurance costs careholders must pay when providing care to children, youngsters, patients released from institutions, etc. The study could include an investigation of potential funding sources and the feasibility of some client absorption of costs.

Funding must be made responsive to the needs of the individual client and the location of the facility. Differentials may be appropriate to allow for variations in cost in densely populated urban areas as opposed to rural areas. A system may be desirable for pooling the resources of several agencies to provide a larger sum of money to adequately serve a client with unusual or multiple problems.

The Social Services Subcommittee of the House Ways and Means Committee has made recommendations to increase some reimbursements. The recommendations may be helpful as a point from which to begin its study effort.

The work being done by the Department of Social and Rehabilitation Services in the State of Kansas might also serve as a point of departure for this effort. Purchase of care rates are determined by the kind and amount of service each individual needs when released into the community. These services might include transportation, health, social services, personal hygiene, specialized needs for home management, self-help, personality modifications, family planning, independent living, legal services, counseling and day care. Within each service, a unit of care is identified and a cost for that unit is determined. Reimbursement is determined by the number of units of service each individual receives. Therefore, it is conceivable that within a community residence, many different reimbursement rates will be received. A relatively sophisticated accountability system has been developed by the State for the private vendors to use in billing.

E. STRATEGIES TO NEUTRALIZE COMMUNITY RESISTANCE

Each agency should be encouraged to review those elements of its deinstitutionalization program which engender community resistance. It must be recognized that there is less resistance to community residences for the retarded, non-delinquent children and the elderly than for other groups. The State may find it more efficient to deal with these groups through the purchase of care from private vendors while using another approach for other client

groups. In some cases, public funding and operation may be the best means of getting those more difficult programs started.

Agencies might consider incremental strategies for establishing community residences. One State agency uses an incremental approach which begins with the establishment of a day program. Once that program is accepted, it is expanded to include a residential component. This phased approach may prove more successful in gaining community acceptance.

It is also possible that the size of some of the proposed community residences is one cause of local concern. Community corrections centers are expected to house over 100 clients. Perhaps the concept of establishing a facility for 100 offenders in a community setting is fundamentally too threatening for residents. In the State of Minnesota, corrections officials have been far more successful in their efforts to set up halfway residences for 15-18 persons. They have felt that any greater number would have exceeded the tolerance of the neighborhood.

Minnesota employs an approach to community corrections whereby the counties have the responsibility for developing community programs for adults and juveniles. If they do not implement this responsibility, the localities are charged a fee of anywhere from $26-$42 per day for those who are sent to the State system for imprisonment who otherwise would be in a community program. These high rates often provide an incentive to the locals to develop community programs.

The concentration of 8+ youngsters may also account for the opposition to JSA group homes. In the State of Florida, officials

have dealt with similar problems by developing a group home program which is an extension of foster care. Instead of 8 youngsters, as in the case of JSA group homes, between 4 and 5 youngsters are placed with a natural family. Only room and board are provided and there are no zoning approvals necessary. However, unlike foster care which purports to house the child until he or she is 18, the group home program houses a child for a short period of time, anywhere from three-six months. Because many of these foster parents have had no training, a counselor who is an employee of the Department of Youth Services supervises and supports the parents, provides the linkage with other support agencies and visits the home 3-5 times per week.

The use of local advocate groups has proved helpful in some cases. The Mental Retardation Administration has relied heavily on the Association of Retarded Citizens to counter community fears and resistance. The ARC practices a very grass roots approach and holds meetings in family homes to discuss retardation and the need for group homes.

Some agencies and program sponsors have found that community participation in assessing needs and guiding program operations can neutralize community resistance. Community participation in the operation of the home helps to insure continuing community cooperation. For example, the Board of Directors of Harford Center, a residential program for mental retardates, is composed of influential county residents who support the efforts of the center before the county council and the community, and also help raise funds. Community boards are also being established

for each community corrections center; the boards are given the authority to hire program directors.

Where persuasion is not successful in gaining community acceptance of a specific site, it may be necessary to have a State or local agency purchase land for the facility. It may not be the most desirable, but it may be the only way to obtain sites for programs to serve those groups that are found to be most objectionable such as youthful and adult offenders. Furthermore, a considerable amount of land already owned by either a State or federal agency regularly becomes available for new uses. Sponsors should seek out these properties as initial choices to avoid the need to purchase sites.

Another approach might be to create a legitimate compromise agent between the State and community residence sponsor and the community. In many communities, the courts have been used as the compromise agent between the State or program sponsor, and the community. Using the courts or another legitimate compromise agent can be an effective strategy.

F. NEED FOR COMMUNITY EDUCATION

It is clear that the strength and perseverance of community resistance to the implementation of deinstitutionalization undermines the future of the movement. Efforts undertaken to educate communities have been successful in that many are aware of deinstitutionalization and seem to approve of it in concept. However, efforts to extend this awareness to acceptance of a community residence in one's own neighborhood have been unsuccessful. Without

residential facilities in communities, deinstitutionalization is seriously hampered.

Despite the uneven success of community education programs, they are essential to any program. Therefore, community education efforts should be planned and executed to include general information on deinstitutionalization as a concept and system; the nature of specific disabilities such as mental illness, mental retardation and alcoholism should also be discussed. This program should be general and not related to any specific site or client group. Leadership from key state officials on this effort would be helpful.

In the past, the State has taken a laissez-faire position on community education, encouraging each sponsor to develop its own process. Such site by site efforts are costly in terms of time and energy. The State, through the policy and program managers' task force proposed earlier, could take responsibility for a Statewide media campaign using the resources of television, radio and print to publicize the need for and advantages of community-based treatment.

The Community Corrections Task Force has attempted to preclude resistance by developing a comprehensive community awareness and education program. In some cases, community opposition has been neutralized by assuring that only persons from their own county will be placed in the community residences to be located in their neighborhood. Taking the initiative with this policy helps alleviate the fear that the neighborhood will be the "dumping ground" for persons in need from other counties.

Local initiative may be desirable in concert with State activity when approval of a specific site is required. Local groups may have better insight into the attitudes and behavior of the community and may, consequently, be more effective educators. Local advocates may also be less threatening to the community and have greater credibility with the community on a site-by-site level. The use of local advocate groups discussed in the previous recommendation could be desirable. This might also produce greater local willingness to participate in facility programs and interact with residents of the facility.

G. THE NEED FOR EVALUATION

Many community residences have been in operation for years, yet attempts to evaluate these programs have been minimal. As a result, potential sponsors do not have the benefit of evaluation with which to educate and persuade community residents on the benefits of these programs. Additionally, decision makers lack the information they need to assess the merits of the deinstitutional approach.

Most sponsors of community residences agree that there is a need for evaluation of community programs. In general, funds have not been made available for this purpose and attempts to self-evaluate are met with suspicion. State program officials have to decide who will evaluate these programs and assure availability of necessary funds.

Monitoring and evaluation can be conducted at two levels. The agency responsible for operating the program should institute regular monitoring procedures. These procedures would provide early

notification of potential problems with funding or services and allow for corrective actions to be taken. Agencies should also attempt to evaluate their programs in terms of their effect on the clients and the community.

To assure objectivity in evaluation, some reviews could be conducted jointly the the Department of Budget and Fiscal Planning and the Department of Fiscal Services and the program managers' task force. Each agency should be involved in determining the basis for the evaluation of its efforts. The evaluation should be broadly based and take into consideration such factors as social and psychological benefits to the clients as well as the actual cost of deinstitutionalization. This would provide an opportunity to compare the true cost of institutional versus community care.

Lastly, in conducting cost-benefit or evaluation studies of community based care, investigators should be concerned with the costs of more than just the physical plant for each kind of program. Considerable attention should be given to the larger question of how much money would be needed to fund community care with the provision of all necessary support services. Such efforts are now going on within the Mental Hygiene Administration. Similar efforts should be conducted in other agencies. There is no point to selling programs for their cost-savings if the savings are resulting from "bare-bones" care.

H. ALTERNATIVES TO COMMUNITY RESIDENCES

In view of the difficulties being experienced in the effort to establish community residences, it might be wise for agencies to begin experimenting with different forms of living arrangements

for people being diverted or released from institutions. Currently, there is some experimentation in the use of the grounds of State institutions for community living. Excess land that buffers a public facility from the surrounding community might be considered as a site.

Another approach which has been suggested is to locate a community residence on the grounds of a State University, and to use college students preferably those majoring in social work, psychology, or medicine to perform the houseparent function. This approach might be advantageous since health and food services already exist on the campus. In addition, the more liberal environment on a college campus might provide a hospitable setting for a group facility.

In redefining the role of the State hospital, which has been suggested in earlier sections, officials should give consideration to the responsibility the hospital has to insure adequate housing for those it releases. The hospital may find that it is advantageous to sponsor housing off the grounds, such as boarding homes, or lodges, for the patients it releases. Hospitals in other states such as Colorado have assumed this responsibility.

Another approach currently being used in the State of Colorado as well as others is the concept of an intentional family. An intentional family is composed of 2-4 persons who have met during treatment, and who choose to live together after release, usually in a large apartment. Various alternatives are used for monitoring the welfare of these individuals. In some cases, the landlord supervisor position is developed; this supervisor receives counseling

and backup from the hospital staff. In other cases, ward staff from the hospital follow the activities of this group.

In one instance in Colorado, this intentional family concept has been expanded to include 12-14 persons. These individuals maintain a large home and contract themselves out for group work such as cleaning and other services. They receive supervision from a work manager who draws up the employment contracts, monitors their performance or assigns them another job. In addition, hospital staff also follow-up on these released patients.

Another alternative is to place an individual in an independent living situation in his own apartment or with one other person. Research has indicated that the more self-supportive mental patients do not want to be closely associated with other patients. In California, the approach is being used with persons released from the Brentwood VA Hospital. Each day a daily meeting is scheduled for the patient with a nursing team member who checks on the health of the patient and has the authority to assign work details. It has also been suggested that college students studying scoiology, psychology, or medicine assume this linkage role as part of their training.

It has also been suggested that program staff try to develop the concept of companion living. Under this approach, the elderly individuals or elderly couples, are asked to provide room and board for person(s) being released from an institution. This role may be well suited to the elderly because many have considerable experience caring for people, large homes with empty rooms and the need for extra funds if they live on fixed incomes.

I. NEED FOR TRANSITION PLANNING

As stated earlier in this report, inadequate transition planning often creates difficult problems for the person being released from an institution. The major reason for inadequate planning is that the organizational structure and staffing patterns in the institutions and supporting agencies have not caught up with the deinstitutionalization concepts. In order to remedy this problem, the following approach should be considered.

The institutional and community staff should be linked in planning for the individual's release. This coordination prior to release will insure follow-up. Institutional staff, in planning for the release of a patient, could take the initiative and contact the community libraries or other sources which have knowledge about the support resources that exist in a community. Upon the completion and operation of the State's multi-service centers, similar information could be obtained from offices in that facility.

J. DEVELOPMENT OF STAFF TRAINING PROGRAMS

State departments must accept the full responsibility for the planning, development monitoring and evaluation of staff training for community residence work. An interagency effort should be started to develop a suitable curriculum; these programs could be offered at the community colleges or in adult education programs. Once training is available to interested persons, a method must be developed for the transfer of this knowledge from one staff person to the next. In order to achieve this, a climate of professionalism has to be transmitted to the new trainees so that they will make a commitment to the work.

K. ENCOURAGEMENT OF JOINT COMMUNITY RESIDENCE PROGRAMS

It has been suggested that joint ventures be encouraged. This possibility could be examined by the Policy Task Force. Several joint venture projects have been suggested. First, the joint use of residential facilities might be considered. Currently, each program sponsor and each State agency is encouraging the development of separate facilities for its own clients. However, some agencies such as SSA, JSA and DAA, have clients with similar patient profiles who do not require long term care. It has been suggested that these clients could be housed in the same facility. This co-location of clients would help create a client group of sufficient size to warrant establishment of facilities in rural areas.

Another joint venture might occur in the provision of services for clients. As stated earlier in this paper, a tendency exists among community residences to develop services if they are not forthcoming from the community. To forestall duplication and excess cost, State program officials could require that several facilities in the area share the expense of providing the service. For example, the costs of hiring a psychologist might be reduced if the individual is hired as a full time employee of two or three facilities rather than as part time employee of several facilities.

The feasibility of establishing a cooperative buying service for the purchase of those articles that are commonly used by all agencies should be investigated. These products might include paper supplies, canned goods, gasoline and vehicles. Although

these costs represent somewhere in the neighborhood of only 15% of a budget, these efforts could produce savings that might relieve some of the financial pressures the facilities are now experiencing.

To accomplish this task, the State agencies responsible for the existence of these facilities would need to provide the leadership. Currently, community facilities operate as independent entities; little coordination exists between them on internal operations. Therefore, requirements for standardization would have to be developed so that purchasing decisions could be made in a timely and coordinated manner. This recommendation could be achieved through the program management task force.

L. REGULATORY PROVISIONS

Earlier in this paper, considerable attention was given to the role zoning ordinances play in the obstruction of deinstitutionalization. In some communities in New York State, program sponsors have taken the issue into the courts. One State court ruled that local jurisdictions could not prohibit a drug abuse program in their community because to do so was a contravention of state policy and programs which encourage the creation of such facilities. Another less direct approach has been taken in New York also; program sponsors simply avoid single family zones.

As a first step in dealing with these problems in the State of Maryland, it is suggested that the Department of State Planning and the Attorney General develop a model zoning ordinance to accommodate community residences in local communities. Standards can be developed for the location, density, parking and other conditions so

that the neighborhood will be protected and land use policies complied with.

Thereafter, upon their request, assistance should be offered to local zoning officials to adopt the ordinance. In working for adoption, the amendment of the zoning ordinance should be an independent issue, apart from any effort to secure approval for a particular site. This strategy will maximize the positive response of community residents to the advantage of deinstitutionalization.

Furthermore, there is a need for other prototype or model regulatory provisions for community residences. As pointed out in the report, there is no specific category for community residences in existing fire or building codes. This situation makes it extremely difficult for sponsors to gain local approval for the sites. A code specific to these facilities, that clearly identified the criteria they had to meet to gain approval, would, at least clarify the rules. The model code could be developed jointly by the Department of State Planning, the Department of Economic and Community Development, the Office of the Attorney General, the Fire Marshall and other appropriate agencies.

APPENDIX

List of Interviews Conducted

Mr. John Bland - Division of Alcohol Control, DHMH

Mr. Harvey Byrd - Governor's Commission on Law Enforcement and the Administration of Justice

Ms. Sara Carter - Anne Arundel County Councilwoman

Mrs. Virginia Dux - Social Services Administration, Department of Human Resources

Ms. Mary Eidelman - Division of Library Development and Services, Maryland State Department of Education

Mr. Ed Goodlander - Harford Haven

Mr. George deHaven - Mental Retardation Administration, DHMH

Mr. Larry Johnson - Frederick City/County Planner

Mr. Charles Kelley - Charles Village Association

Mr. William Lamb - Community Corrections Task Force, Department of Public Safety and Correctional Services

Mr. Warren Lamson - Mental Hygiene Administration, DHMH

Mr. William Litsinger - Juvenile Services Administration, DHMH

Mr. James McSherry - Attorney, Frederick, Maryland

Mr. Jim Partridge - Division of Library Development and Services, MSDE

Mr. William Platter - Longstretch Youth Homes

Mr. J.C. Robertson - State Fire Marshall

Mr. Al Rocklin - Second Genesis

Ms. Julia Schamp - Mental Hygiene Administration, DHMH

Mr. Earl Seboda - Capital Budget, Engineering and Maintenance, DHMH

Ms. Barbara Seidenberg - Drug Abuse Administration, DHMH

Mr. Morris Sherman - Mental Hygiene Administration, DHMH

Dr. Pat Smith - Aged and Chronically Ill Services Administration, DHMH

Mr. Dave Treasure - Drub Abuse Administration, DHMH

Mrs. Ellen Woodland - Cedar-Morris Hill Improvement Association